PROJECT NARRATIVE

Connecticut (CT) is seeking to establish a whole-person-centered healthcare system that improves population health and eliminates health inequities; ensures superior access, quality, and care experience; empowers individuals to actively participate in their healthcare; and improves affordability by reducing healthcare costs. CT's Model Test is the vehicle for achieving this vision. It is the product of two years of planning, including input from 25 consumer focus groups, an extensive survey of approximately 800 consumers, and more than 60 multi-stakeholder meetings. ***Our Model Test drives accountability, consumer engagement and high quality of care, featuring: 1) development of a comprehensive evidence-based plan for improving population health; 2) initiatives to strengthen primary care and integrate community and clinical care; 3) value-based payment and insurance design; and 4) multi-payer alignment on quality, health equity, and care experience measures.***

I. Plan for improving population health

Background: The Plan for Improving Population Health ("Plan") will utilize and build upon the Department of Public Health's (DPH) recent State Health Assessment, State Health Improvement Plan (*Healthy Connecticut 2020)* and the state Chronic Disease Prevention Plan. These plans are characterized by a dual emphasis on state-wide population health improvement and achievement of specific health equity objectives. Plan Lead: Plan development will be led by DPH in collaboration with the Department of Social Services (DSS), which administers the CT's Medicaid program, and the State Innovation Model Program Management Office (PMO), which will ensure integration of population health interventions with the care delivery and payment innovations of the Model Test.

***Stakeholder Engagement and Governance*:** A health systems workgroup was established previously under a broader 150-member, multi-sector Healthy Connecticut 2020 planning coalition. This workgroup will be reconvened as the Population Health Council and enhanced to include payers and health care providers for the purposes of: 1) identifying additional state health priorities relevant to the Model Test (e.g. child wellness); 2) identifying barriers to population health improvement; and 3) recommending specific evidence-based strategies to address tobacco, obesity, diabetes and other identified priorities. Priority-setting of health improvement areas will be accomplished using a modified Hanlon method used in *Healthy Connecticut 2020*, supplemented by state-specific local data, financial and disease burden analyses and guided by CDC technical assistance. Barriers to improving health in prioritized areas will be identified by root cause analyses related to the social determinants of health (e.g., Frieden's Health Impact Pyramid) focusing on barriers most likely to contribute to health inequities. Evidence-based strategies from expert sources will be selected (e.g. Guide to Community Preventive Services).

***Key data sources*:** Enhanced Behavioral Risk Factor Surveillance Survey (BRFSS) sampling will provide baseline and ongoing capability to conduct small area analyses for tobacco, obesity and diabetes and other identified health priorities. Other data sources include mortality data, hospital and ED discharge data and existing community health needs assessments. The state will consider expanding the state's reportable diseases database to include chronic disease indicators for population health activities once a fully-functioning statewide Health Information Exchange (HIE) system is available.

Policy, Sustainability and Implementation: Design and implementation of two sustainable primary population health enabling structures will be considered: 1) Prevention Service Centers (PSCs), community-based entities offering evidence-based community preventive services in

affiliation with providers, and 2) Health Enhancement Communities (HECs) in areas with the greatest disparities, targeting resources and facilitating local coordination and accountability among providers, local public health departments, nonprofits, schools, housing authorities and others through innovative financing strategies (e.g., wellness trusts) and multi-sector governance solutions (e.g., local coalitions led by a fiduciary agent). Evidence-based policies and strategies will be linked with reimbursement innovations to address social determinants of health and health equity (e.g., reimbursement for healthy homes assessments and community health workers). A proposed timeline is: Year 1: Complete population health assessment; prioritize health conditions and identify interventions; Year 2: Develop PSC and HEC concept and plan; identify additional population health and health equity metrics for evaluation and monitoring; Year 3: Implement plan for PSC and complete detailed design of HEC proposal; Year 4: Implement PSC demonstration and finalize HEC proposal.

Potential innovative financing strategies for Health Enhancement Communities:

In 2018, informed by the results of the return on investment analysis, the Population Health Council will be tasked with making a recommendation on mechanisms to finance Health Enhancement Communities. One or a combination of the following strategies will be considered.

- The initial phase will include seeking State Appropriations for startup costs in SBY 18/19 (see response to question 1a) and additionally establish a dedicated wellness trust fund to capture a portion of the anticipated savings. Savings could potentially be captured by a small assessment on entities realizing or most likely to realize savings from the implementation of HECs (e.g. payers, healthcare organizations). Alternatively, entities realizing such savings may realize a business-case and be willing to make up-front and ongoing financial

commitment to the wellness trust fund. This assumes that shared savings rewards will be linked to measured community-wide performance in areas that are a direct focus of HEC efforts.

- Opportunities to align grant funded programs around a HEC will be sought. For example, Stamford, CT has already harnessed HUD and EPA resources to help fund a Health and Wellness District initiative http://vitastamford.com/about-vita/. In addition, CDC funds numerous disease prevention and control initiatives, many administered by DPH and implemented at the local level (e.g. healthy food retail, local active transportation initiatives, medication therapy management) which offers opportunity to align programs around the concept of HEC.
- Finally, The Department of Social Services will review all available options for State Plan and waiver authority in support of HECs. For example, by enabling reimbursement for community health workers and bundled payments for trauma-informed wrap-around interventions for children and families.

Potential multi-governance solution for Health Enhancement Communities:

A variety of governance solutions will be considered by the Population Health Council during the HEC design phase in years 2-4. The planning process will include a survey of emerging national models such as those in use in Washington (Accountable Care Organizations), Oregon (Coordinated Care Organizations), and Minnesota (Hennepin County). Additional examples include:

- Lead Fiduciary Agent Model: Beginning in 2011, DPH has administered the CDC's Community Transformation Grant in five of CTs eight counties. Because CT lacks a county government structure, one health district from each county was charged with fiduciary

oversight and program coordination through establishing county-wide multi-sector, community coalitions and developing and executing local plans to implement policy, environmental, and infrastructure changes related to the CTG strategic areas (smoking, healthful living and preventive services). Such a coalition-based model could be focused and modified to serve the governance needs of HECs. Similar approaches are being employed by Maryland's Health Enterprise Zone initiative and lessons learned from that initiative are anticipated to be available to inform HEC governance design.

The Lead Fiduciary Agents for the five counties awarded funding for CTG were the following local health districts:

- Litchfield County / Torrington Health District
- Middlesex County / Chatham Health District
- New London County / Ledge Light Health District
- Tolland County / Eastern Highlands Health District
- Windham County / Northeast District Department of Health

This approach made sense since the Department of Public Health (DPH) has an on-going strong relationship with local health districts, partnering on a variety of "public health" projects in meeting the overall mission of DPH.

What further enhanced this model, is that the Lead Fiduciary Agents chosen for CTG, based on past state and/or national funding, had existing and sustainable coalitions and partnerships in their respective County to support the three CTG strategic directions mandated by CDC: 1) active living/healthy eating; 2) tobacco free living; and 3) quality clinical preventative services.

Key outcomes/points using the Lead Fiduciary Model during the three year CTG project:

1. The lead fiduciary agents:
    a. Dispersed CTG funds in their respective Counties
    b. Coordinated and submitted all fiscal, data and progress reporting for the grant cycle to DPH
2. Each County created a comprehensive Needs Assessment
3. Each County pilot tested "systems, policy and environmental change" initiatives to support the three strategic directions

Illustrative outcomes:

- 16 municipalities implemented new smoke free policies (e.g. no smoking in public parks)
- Twelve schools have new healthy eating or physical activity opportunities (e.g. school gardens, class-room integrated walking initiatives, or after school programs)
- 4 out of the 5 lead fiduciary agents secured linkages with health systems serving the county and in 2 instances engaged in joint programming around self-blood pressure monitoring.

- Health Neighborhood Model: In support of implementing the CMMI Demonstration to Improve Care for Medicare-Medicaid Enrollees, DSS has conceptualized new, multi-disciplinary provider arrangements called "Health Neighborhoods" (HNs). These provider networks will be supported in data analytic and other functions by the Medicaid medical Administrative Services Organization (ASO), and will formally organize across provider types through care coordination contracts, electronic means and a learning collaborative in furtherance of holistic and coordinated support of members' health needs. This network

approach represents another kernel that could be expanded to provide a multi-sector governance solution in support of HECs.

Differences between Prevention Service Centers and Health Enhancement Communities:

Prevention Service Centers are community-placed organizations that would meet criteria for the provision of evidence-informed, culturally and linguistically appropriate community prevention services. Prevention Service Centers may be new or existing local organizations, providers (e.g., FQHCs), non-profits or local health departments. Prevention Service Centers will initially focus on environmental quality issues in homes and promoting positive health behavior (e.g. asthma home environmental assessments, diabetes prevention programs, and falls prevention). Prevention Service Centers will foster alignment and collaboration between primary care providers, community-based services and State health agencies. Their workforce will include existing workers providing similar services (e.g. local health department staff, Area Agencies on Aging, FQHC staff) and the emerging cadre of community health workers envisioned as part of our healthcare workforce development strategy.

Building upon ongoing efforts by the public health and local communities, the SIM proposes a new initiative to create Health Enhancement Communities (HECs). The purpose of these newly created HECs will be to intensify and coordinate community resources to improve health in areas with the highest disease burden, worst indicators of socioeconomic status and pervasive and persistent health disparities. The Health Enhancement Communities (HECs) will be collaborative multi-sector partnerships—alliances among people and organizations from multiple sectors working together to improve conditions and outcomes related to health and well-being of entire communities. This model is well-established and variations of the model are being implemented

with respect to community health interventions in numerous states, including Connecticut. We anticipate that Prevention Service Centers would be among the multi-sector participants.

One example of an effective collaborative partnership, referenced previously in the response to question #12, is a health and wellness district jointly sponsored by Charter Oak Communities, City of Stamford and Stamford Hospital. The vision is not only to revitalize the economic health and well-being of Stamford's West Side residents but also to ensure a health and wellness destination that can improve the quality of life for the entire city. Areas of focus include expanding access to healthier food, fitness opportunities, and preventive health and medical care as well as job training and workforce development. Informed by a local Community Health Needs Assessment (CHNA) and a collaborative strategic planning process, the initiative is well underway and has achieved a number of accomplishments.

II. Health Care Delivery System Transformation Plan

Advanced primary care practice is the foundation for a high-performance healthcare system. CT consumers, providers, and other stakeholders believe that strong primary care is a strategic health policy goal and requires redesigned primary care practices with accountability measures for performance on patient outcomes, care experience, and resource utilization that are linked to a new payment reform approach. The CT Model Test prioritizes **five core elements to move toward advanced primary care practice**: 1) whole-person-centered care; 2) enhanced access without disparity; 3) population health management; 4) dynamic, team-based coordinated care; and 5) evidence-informed clinical decision making. **These core elements -- plus quality measure alignment, value-based insurance design, robust data infrastructure, payment innovation, and an enhanced workforce --will collectively support achievement of the "triple aim" of better health, better care and reduced costs.**

Our Model Test will determine whether a comprehensive set of **statewide transformation initiatives** will accelerate improvements in the performance of the health care system for all of Connecticut residents. These initiatives involve nearly all payers, providers, and a diverse array of stakeholders. They include activities in the aforementioned areas of quality measure alignment, value-based insurance design, health information technology, payment reform and workforce development and they are intended to benefit **the entire care delivery system and all CT residents statewide.**

Our Model Test also introduces a targeted, three-part strategy to transform primary care in CT: 1) an Advanced Medical Home Glide Path; 2) the Community and Clinical Integration Program; and 3) Statewide Learning Collaboratives. **These programs will focus on a subset of providers that participate in a newly established Medicaid Quality Improvement and Shared Savings Program (Medicaid QISSP)** that will be described in the Payment and Service Delivery Model section. We hypothesize that our three part strategy outlined below to transform primary care, combined with the Medicaid Quality Improvement and Shared Savings Program, will further accelerate the pace of change and performance of participating providers relative to non-participants, and that the improvement in performance will be of particular benefit to Medicare, Medicaid and CHIP beneficiaries who have chronic illnesses, significant care coordination needs, and/or social determinant risks. We intend to implement this three part strategy in three waves, two of which will occur during the test grant. Over the course of five years, a substantial majority of the state's primary care community will participate in Medicaid QISSP and will have the proposed advanced primary care capabilities.

Statewide Interventions	**Targeted Interventions**
Plan for Improving Population Health	Medicaid QISSP

Quality Measure Alignment	Advanced Medical Home Glide Path Program
SSP based on Care Experience/Quality	Community & Clinical Integration Program
Value Based Insurance Design	Innovation Awards
Workforce Development	Learning Collaboratives
HIT / Analytics / Performance Transparency	

Primary Care Transformation: CT has approximately 3,300 primary care physicians, 1,200 primary care advanced practice registered nurses (APRNs), and 1,000 physician assistants (PAs). These figures include an estimated 280 primary care providers (PCPs) in 14 federally qualified health centers (FQHCs) who care for more than 340,000 individuals each year. Nearly 3,400 PCPs are estimated to work in 15-17 *Advanced Networks* –which we define as independent practice associations, large medical groups, clinically integrated networks, and integrated delivery system organizations that have entered into shared savings plan (SSP) arrangements with at least one payer. Many of these Advanced Networks include one or more anchor hospitals. More than 1,900 PCPs are in unaffiliated, independent practice settings.

All of CT's FQHCs will be nationally recognized as medical homes under NCQA 2011 standards or Joint Commission standards by the end of this year. Although many independent practices and those affiliated with Advanced Networks have pursued practice advancement, only about 600-700 PCPs in CT have achieved or maintained NCQA 2011 medical home standards. **Many practices are prepared to pursue medical home recognition, but lack the resources and support necessary to begin that process. Similarly, many Advanced Networks with a strong advanced practice foundation want to move to the next level but lack the funding and technical expertise necessary to re-engineer their processes, incorporate new**

technologies, or develop more sophisticated clinical and community integration capabilities. Our three-part strategy to transform primary care addresses these needs.

Advanced Medical Home (AMH) Glide Path: In 2012, DSS established a glide path program to provide practical, on-site technical support to facilitate practice transformation towards medical home recognition. The PMO will leverage this DSS program to establish a multi-payer AMH Glide Path. The PMO will enroll a total of 500 primary care practices, with 250 practices in each of two waves during Years 1 and 3 of the test period. AMH Glide Path support will be offered first to Advanced Networks that are participating in the Medicaid QISSP and who have practices that are not yet recognized as medical homes. AMH Glide Path support will be available to non-participating primary care practices within available resources. The AMH Glide Path will utilize NCQA standards and additional CT-specific standards to be developed by the Practice Transformation Taskforce comprised of state Medicaid officials, representatives from all five of CT's major health plans, employers, providers and consumers. Participating practices will be required to achieve NCQA recognition in order to complete the Glide Path. The PMO will contract with vendors to provide practice transformation support over 9 to 18 months. DSS will provide operational support for the AMH Glide Path Program, including providing health plans with information regarding AMH Glide Path enrollment, achievement of milestones, and designation status.

Community and Clinical Integration Program (CCIP): The CCIP will offer Targeted Technical Assistance (TTA) and Innovation Awards to Advanced Networks and FQHCs, selected to participate in Medicaid QISSP. CCIP will accelerate advancement and spur investments in the following priority areas: 1) integrating behavioral health and oral health integration, 2) providing medication therapy management services, 3) building dynamic clinical teams, 4) expanding e-

consults between primary care providers and specialists, 5) incorporating community health workers as health coaches and patient navigators, 6) closing health equity gaps, 7) improving the care experience for vulnerable populations, 8) establishing community linkages with providers of social services, long term supports and services (LTSS), and preventive health; and 9) identifying "super utilizers" for community care team interventions. FQHCs have identified two additional priority areas: 1) enhancing primary care provider/staff skills in quality improvement methods and analytics; and 2) producing actionable quality improvement reports. The PMO will contract with vendors to provide TTA across the 11 CCIP priority areas listed above.

Finally, CCIP will include a competitive Innovation Awards program to support transformational demonstration pilots that align with CCIP priorities. The PMO will establish an Innovation Awards advisory committee to establish award criteria and processes. These awards may include matching or in-kind requirements for larger Advanced Networks, which will not be required for FQHCs.

The state will procure one or two vendors to provide practice transformation services within the Community and Clinical Integration Program (CCIP). We anticipate that one vendor may be sufficient to administer the CCIP for both FQHCs and Advanced Networks; however, we will consider an additional vendor if a second vendor is needed for reasons of bandwidth (i.e., the capacity to engage multiple providers simultaneously) or if it appears that a second vendor is needed with specific experience and expertise in working with FQHCs and their associated vulnerable populations and organizational structures. In addition, we expect that these practice transformation vendors will subcontract with 8-10 subject matter experts who have substantial expertise and experience with the 11 TTA topic areas.

The CCIP program will spur investment and accelerate advancement in two ways. The CCIP program will be offered to Advanced Networks and FQHCs that successfully compete to participate in the Medicaid QISSP program. Selection criteria will include a requirement that respondents commit to investing in the development of organizational capabilities, with attendant timeframes and milestones, during the performance period. Thus, the RFP competition will spur commitments to invest. In addition, the TTA will provide technical resources to accelerate advancement, beyond the level of performance these providers would otherwise achieve if they did not receive such assistance and did not commit to necessary investments.

The Innovation Awards program (part of the CCIP) will also, through a competitive process, require a commitment to invest in the development of organizational capabilities, with attendant timeframes and milestones, during the performance period. We will determine during the next phase of planning whether we will require specific in-kind investments in order to qualify for the awards. In summary, the Innovation Awards process will spur investments through competition and it will accelerate advancement through the provision of grant resources and a structured grant administration process.

*Learning Collaboratives (LCs)**:*** The PMO will establish three learning collaboratives. The first will focus on practices enrolled in the AMH Glide Path. The second and third LCs will be tailored to FQHCs and Advanced Networks participating in QISPP. LCs will foster continuous learning through webinars, workshops, an online collaboration site, and phone support. Practices will be expected to actively share resources, tools, and strategies with each other in the LC. LC participants will report quarterly progress on achieving milestones to track transformation.

Healthcare Workforce Development: Our Model Test includes a healthcare workforce component to address the need for training in newer models of multi-disciplinary and coordinated care. The Model Test includes three workforce initiatives in support of this goal: *Inter-professional education (IPE):* The Area Health Education Center (AHEC) will invite all CT health professions schools/programs to participate in the Connecticut Service Track (CST), and will work with them to develop and incorporate inter-professional, team-based curricula and sponsor IPE training sites throughout the state in accordance with the CST model."

The proposed Connecticut Service Track (CST) is an expansion of our nationally acclaimed Urban Service Track. The Urban Service Track serves Connecticut's disadvantaged urban communities and includes UConn's medical, nursing, pharmacy and social work schools plus Quinnipiac's physician assistant program. CST will serve disadvantaged populations throughout Connecticut, and our aim is to include all of Connecticut's professions schools and primary care residency programs.

All Urban Health Scholars participate in a two-year curriculum that complements the existing curricula in the six schools and focuses on 11 competencies. Faculty includes university and community health center clinicians, patients and other community partners. UST explores the 11 competencies in terms of the needs of a number of vulnerable populations: children/youth, the elderly, individuals with HIV/AIDS, incarcerated and ex-offender populations, immigrants/refugees, disparity populations, veterans and people who abuse substances. Students participate in problem-based learning activities that include clinical skills and case studies.

In addition, attention is paid to the skills needed for interprofessional teamwork. There are formal quarterly learning retreats, community outreach activities, community based research, advocacy and leadership education. Critical to the success of UST is the opportunity for students

to apply knowledge and skills gained in real world settings. This is done through a variety of community outreach activities that focus on health promotion, education, health risk screenings and health careers awareness for individuals from underrepresented backgrounds.

Mentors drawn from both the participating schools and the community instruct students in leadership, effective management of a team, working with team members with different skills and education, effective utilization of community partners and preceptors, and grant writing.

UST has been effective at persuading students to go into primary care. In 2013, students who have graduated from UST were surveyed to determine whether the program positively impacted their desire to work in primary care and with medically underserved communities. 59.6 percent reported that it had contributed to their choice of primary care, and 56.9 percent reported that it contributed to their desire to work in medically underserved communities.

Community health worker training: CT's Model Test anticipates that CHWs will be integrated into primary care teams as health coaches and patient navigators, and will also provide prevention services in a variety of settings. AHEC has partnered with three community colleges to provide basic and specialty CHW training programs that are tailored to the needs of diverse consumers and prospective employers.

Primary care capacity: The CT Teaching Health Center Coalition (comprised of eight FQHCs) and the Community Health Center Association of CT (CHCACT) propose to develop and operate two or more primary care medical residency programs. Model Test funding will support the design of residency programs, with input from health centers and hospitals statewide; longer-term funding support will be sought through a Teaching Health Center grant from the Health Resources and Services Administration.

All of the executive directors of CT's FQHCs are members of Community Health Center Association (CHCACT) board, which this coming year is being chaired by Jim Maloney who is executive director of Greater Danbury Community Health Center, CT's first teaching health center. On September 8, Staywell Health Center in Waterbury in conjunction with Griffin Hospital will announce a second track of Danbury's internal medicine residency program. Our objective is residency programs in several primary care disciplines. In addition to our existing internal medicine residency program, we are currently looking into developing programs for family medicine and children's dental medicine, but we may ultimately consider other disciplines as well. Each residency program will include multiple health centers. We anticipate individual health centers may participate in more than one residency, and we anticipate that all the residency programs will be coordinated with each other. We seek a statewide network. We expect to approach HRSA for additional support in 2015.

III. Payment and Service Delivery Model

CT's payment and service delivery model will demonstrate that performance and value can be increased through (1) primary care accountability for quality, care experience and total cost under shared savings programs; and 2) value-based insurance design (VBID) that engages consumers and reduces barriers to critical prevention and treatment services.

All of CT's health plans, Medicaid, and the state employee health plan have committed to implementing value-based payment arrangements through shared savings programs (SSP) for providers with sufficient scale and capabilities, modeled upon the Medicare SSP.

In the past two years, considerable market consolidation has resulted in an estimated 65% of CT's PCPs employed by or affiliated with a provider organization that is participating in at least one SSP contract, and this percentage is growing. The CT State Medical Society is working to

establish a statewide Medicare SSP network for the remaining PCPs that do not yet have such affiliations.

Medicaid QISSP: In the above context, DSS seeks to establish and test a complementary SSP, which will improve care and reduce costs for vulnerable populations. DSS will undertake a competitive procurement of advanced networks and FQHCs to participate in the Medicaid QISSP. Selection criteria will be established through an intensive stakeholder engagement and design process to conclude in early 2015. Criteria may include demonstrated commitment, experience and capacity to serve Medicaid beneficiaries; ability to meet identified standards for clinical and community integration; a willingness to invest in special capabilities such as data analytics, quality measurement and rapid cycle improvement efforts; and a minimum of 5,000 attributed single-eligible Medicaid beneficiaries. The selection process will prioritize providers who are participating in Medicare and commercial SSP arrangements to maximize multi-payer alignment, practicing in areas of critical need in the state for the Medicaid population, as evidenced by disease burden, disparities and cost of care.

DSS will include an estimated 200,000 to 215,000 beneficiaries in the first of two waves conducted during the test period. The wave one procurement will occur in 2015, with the performance period beginning January 1, 2016. The second wave procurement will occur in 2017, with the performance period beginning January 1, 2018. DSS will implement advance payments for participants in the Medicaid QISSP using an established Medicaid Management Information System (MMIS) based payment methodology that ties enhanced fees to specific primary care services, depending on the level of medical home recognition. DSS will use its current PCMH retrospective attribution methodology to evaluate performance and determine eligibility for upside-only SSP payments. Medicaid and health plans will tie their SSP payment

calculations to the achievement of performance targets using a common scorecard for access, quality, care experience, health equity, and cost. This will reduce complexity for providers and confusion for consumers, while increasing the business case for investment in new capabilities to achieve specified targets.

The Medicaid QISSP does not address the challenge of individual FQHCs not having sufficient attributed members with private payers or Medicare to enter into SSP arrangements. To maximize statewide impact of valued-based payment reform, the PMO will offer support to FQHCs to pool their panels and enter into SSP contracts with private payers and to form an ACO for the purpose of participating in the Medicare SSP, both by the final year of the test period.

DSS relies on Administrative Services Organization (ASO) agreements to manage medical, behavioral health, dental and transportation benefits. Its medical ASO provides customer service, data analytic, quality improvement and intensive care management (ICM) functions for all of the state's Medicaid beneficiaries. The care coordination and analytic capabilities of Medicaid QISSP participating Advanced Networks and FQHCs will be supplemented as necessary by the medical ASO's federated data analytic and ICM supports to improve their performance.

The Department of Social Services' ("Department's) MMIS contractor (HP) and medical ASO contractor (CHN) have no prior experience in Connecticut, per se, with assessing eligibility for, and distributing, shared savings payments to providers. That said, CHN has experience in assessing eligibility for supplemental (performance) payments for the Department's Person Centered Medical Home (PCMH) initiative and for the state-funded obstetrics pay-for-performance pilot. In addition, business processes have been established under which HP has distributed these payments. In support of the QISSP, the Department proposes the following:

- Development of a shared savings methodology with its actuarial contractor, Mercer;

- Administration of a beneficiary attribution methodology by CHN that is the same as or substantially similar to the methodology currently in use for the PCMH initiative;
- Assessment of eligibility for shared savings payment by CHN; and
- Distribution of shared payments by HP using business processes similar to those employed for distribution of performance payments.

Alignment with Medicare Payment Models:

Our proposal is grounded in the belief that advanced primary care practice is the foundation for a high-performance, accountable healthcare system. Therefore, the CT SIM proposal is a transformational model with elements than span both the ACO Medicare Shared Savings Program (see Appendix A) and Comprehensive Primary Care Initiatives (see Appendix B).

Medicare Shared Savings Program (SSP)

All Connecticut payers have committed to a payment model that is broadly aligned with the Medicare SSP. Features relating to organizational structure, measure set and shared savings methodology will require further review by the relevant stakeholder groups associated with the SIM and Medicaid to recognize the current stage of development and readiness in Connecticut as well as the need for additional population-specific measures.

- Organizational Structure - A substantial majority of Connecticut's primary care providers are employed by or affiliated with one of 15 to 17 Advanced Networks, which we define as independent practice associations, large medical groups, clinically integrated networks, and integrated delivery system organizations that have entered into shared savings plan (SSP) arrangements with at least one payer. All of these Advanced Networks are organizing to meet, or have already met, the federal definition of a Medicare SSP Accountable Care Organization, as outlined in Appendix A. For these networks, Medicare SSP already

represents a de facto standard. By contrast, Federally Qualified Health Centers (FQHCs), which currently serve the primary care needs of over 200,000 Medicaid beneficiaries, are at a more nascent level in determining how best to align their organizational structure with Medicare SSP standards. Connecticut's FQHCs are interested in participation in the Medicare SSP, including the option of participation in a regional ACO, and will explore the mechanism and necessary commitment of public resources that would be needed to expand the SSP from the FQHC Medicaid population to their Medicare patients. Consistent with its commitments to transparency and stakeholder engagement, the Department of Social Services will present the Medicare Shared Savings Program ACO structural standards to the relevant committee of its statutorily established stakeholder group, the Medical Assistance Program Oversight Council, for review and consideration as requirements for the advanced networks that will be selected under the QISSP Request for Proposals.

- Measures - Connecticut concurs that substantial alignment among payers around quality measures is essential. The SIM Quality Council has already committed, as a guiding principle, to maximize alignment with the Medicare ACO measure set. That said, the Council will also use a series of five meetings over the course of fall 2014 to examine the need for additional measure elements of particular interest and concern to Medicaid and other payers. Examples of these include, but are not limited to, measures related to pediatrics, health equity, and behavioral health, drawing from measures endorsed by the National Quality Forum and those that comprise the Medicaid Adult and Child Health Care Quality Measures, the Physician Quality Reporting System, and CMS Meaningful Use Clinical Quality Measures. Consistent with its commitments to transparency and stakeholder engagement, the Department of Social Services will present the Medicare Shared Savings Program ACO

measure set, as well as additional measure elements proposed by the SIM Quality Council, to the relevant committee of its statutorily established stakeholder group, the Medical Assistance Program Oversight Council, for review and consideration as component elements of the QISSP Request for Proposals.

- Shared savings methodology - Each payer individually negotiates requirements related to minimum attributed lives, minimum savings threshold, and percent of savings shared. As indicated in the Connecticut application, Medicaid will limit its shared savings initiative (QISSP) to upside risk only. We believe that alignment on the above listed parameters is not necessary to achieve the goals of our Model Test, and do not intend to pursue standardization unless this approach creates challenges for provider participants. As a general principle, we are focusing our efforts at alignment on other areas (e.g. measures) deemed essential by our Healthcare Innovation Steering Committee and other advisory bodies. We have completed Appendix A with these assumptions in mind.

With additional time, we would be pleased to provide a matrix illustrating payer specific policies as it pertains to each of the requirements in Appendix A, including Medicaid pending the completion of their planning process later this year.

Comprehensive Primary Care Initiative

Our statewide, multi-payer recognized Advanced Medical Home Standards will be based on the NCQA 2014 standards and NCQA recognition will be a requirement of completing our Glide Path. As such, these new standards, combined with requirements that are the focus of our multi-payer Community and Clinical Integration Program, align with all of the care delivery capabilities that are outlined in Appendix B.

Level of Commitment Among Connecticut's Commercial Payers:

We define Connecticut's major commercial payers as those with over 5% market share. These payers include the following based on 2013 coverage data:

Commercial Payer	**Market Share**
Aetna	12.7%
Anthem	48.2%
Cigna	23.8%
Connecticare Insurance Company, Inc	7.6%
UnitedHealthCare Insurance Company	7.6%

In addition, we have been working closely HealthyCT, which in 2014 began offering individual coverage on our health insurance exchange, and Harvard Pilgrim, which is also preparing to enter the Connecticut market.

All of Connecticut's payers have strongly endorsed a transition from volume to value-based payment as evidenced in the following excerpts from their letters of support. All payers have, as of the submission of this response, specifically endorsed broad alignment with the Medicare SSP.

Under-service Monitoring:

CT acknowledges that providers in SSP arrangements may seek savings through under-service, which might include reducing necessary access, inappropriate patient selection, cost shifting, withholding appropriate care or inappropriate referral practices. CT has established an **Equity and Access Council** comprised of physicians, consumer advocates, payers, and researchers from the state's public academic health center to develop methods that will help guard against such risks. DSS will not implement the Medicaid QISSP until reasonable and necessary methods for

monitoring under-service are in place, and will make ongoing adjustments to these methods as appropriate. All payers commit to the principle that providers be disqualified from receiving shared savings if they demonstrate repeated or systematic failure to offer medically necessary services, whether or not there is evidence of intentionality. Additionally, the state will leverage the dispute resolution role of its Office of the Healthcare Advocate to adjudicate consumer complaints of suspected under-service.

***Participation Projections*:**

Table 1 summarizes the number of PCPs that are projected to participate in one or more SSP reforms during the next five years. Table 2 illustrates the number of beneficiaries that are projected to obtain their care from a PCP who is accountable for the quality of their care, care experience and total cost. Provider participation rates for the Medicaid QISSP and three-part strategy are contained in the operational plan. Provider and beneficiary participation assumptions are further detailed in Appendix C, Tables 1-6.

Table 1: PCP Participation in SSP

PCP Type	Base	2016	2017	2018	2019	2020
APRN	803	880	957	1034	1111	1173
PA	654	717	780	843	906	956
Physician	2135	2340	2545	2750	2955	3120
Total	**3592**	**3937**	**4282**	**4627**	**4972**	**5249**

Table 2: Number of Beneficiaries with PCP in SSP

Coverage Category (000's)	2015	2016	2017	2018	2019	2020
ASO (excluding State Employees)	336.6	453.7	630.7	753.6	879.1	1,007.2
Fully insured	260.1	350.6	487.3	582.3	679.2	778.2

Coverage Category (000's)	2015	2016	2017	2018	2019	2020
State employees, exc. Medicare Supp.	40.7	54.8	76.2	91.0	106.2	121.6
Medicare	175.4	240.8	340.8	414.5	492.3	574.3
Medicaid/CHIP*	0.0	204.9	209.7	429.1	439.1	636.5
Total	812.8	1,304.8	1,744.7	2,270.5	2,595.9	3,118.0

*Includes approximately 137,000 single adults enrolled in the Medicaid Expansion

Value-Based Insurance Design (VBID): CT's largest employers and healthplans recognize the importance of demand side levers such as VBID to increase consumer engagement in health improvement and reduce barriers to effective self-management of chronic illness. **The PMO will undertake extensive VBID adoption efforts**, convening employers, business groups such as CT's Business and Industry Association, healthplans, providers and consumers to provide input on VBID design; develop prototype VBID plan designs that align supply and demand while enabling streamlined administration; and provide a mechanism for employers to share best practices to accelerate the adoption of VBID plans. With respect to specific programmatic activities, the PMO will: 1) establish a VBID baseline; 2) conduct a VBID/ACO comparative effectiveness study; 3) establish an employer-led consortium with core interest sub-groups (e.g. clinical, wellness, administration) and linkages to regional and national forums such as CMMI's VBID learning cluster to enable peer-to-peer sharing of best practices; 4) develop VBID template(s) and implementation toolkits; 5) convene an annual learning collaborative, including panel discussions with nationally recognized experts and technical assistance; and 6) facilitate a workforce health outcomes pilot. In addition, subject to board approval, Access Health CT will implement VBID in Year 2 of the Model Test. CT's Medicaid program currently features VBID with its grant-funded Rewards to Quit tobacco cessation incentive. DSS will consider the

implementation of additional incentives in alignment with the development of the state's population health plan.

IV. Leveraging Regulatory Authorities

Connecticut has demonstrated that it is **committed to using legislative and regulatory authority to support healthcare delivery and payment reform**. Recent health care related legislative initiatives include: 1) establishing the CT Health Insurance Exchange (Access Health CT) (PA11-53); 2) expanding Medicaid (PA11-44); 3) reducing state employee healthcare costs associated with facility fees (PA14-217); 4) expanding CT's False Claim Act to encompass all health and human service agencies, programs, and employees/retirees (PA14-217); 5) disclosing observation status to patients (PA14-180); and 6) establishing the CT Institute for Primary Care, a cooperative venture of the state's public academic medical center and St. Francis Hospital for the purposes of advancing primary care transformation (PA 10-104).

Additional recent legislative and policy initiatives align with our objectives under SIM and create opportunities for integration with our ongoing SIM program design and implementation activities. Several examples are as follows:

- Public Act (PA) 14-217 established funding for the PMO, which enables the PMO to play an ongoing role in the coordination and integration of state agency, provider, payers, and stakeholder activities, including beyond the period of performance for the SIM grant.
- PA14-148 requires DPH to develop a chronic disease prevention and reduction plan consistent with the Innovation Plan, which provides the opportunity to integrate DPH's overarching chronic disease prevention and reduction plan with specific systemic changes in community governance, accountability and health care financing as envisioned as part of the Health Enhancement Community concept. SIM will bring greater focus on maximizing the

use of public and private health financing levers to reward providers and other community entities for achieving population health goals.

- PA13-247 established the All-Payer Claims Database (APCD), which will be the primary source for data to enable evaluation of SIM related care delivery and payment reforms.
- PA14-168 helps ensures competitive healthcare markets by requiring Attorney General notification and the submission of information regarding material changes to the business or structure of physician group practices. This law also requires annual filing of hospital, system, and physician group affiliation to enable the state to better monitor the impact on competition and price as providers organize and consolidate to assume accountability under SIM related payment reforms. The inclusion of new certificate of need requirements regarding transfers of ownership of certain physician group practices to any entity other than physicians or physician groups will provide the state with additional control over such consolidation. These activities are important in light of evidence nationally that the gains in waste reduction and quality achievable in larger systems (and enabled by CT's SIM initiative) can be countered by reductions in competition and associated increases in pricing.
- PA14-12 permits APRNs who have been licensed for at least three years to practice independently. The implications of this change will be considered by the Practice Transformation Task Force as it considers the role of APRNs within health care teams and the context of medical home recognition.
- PA14-211enables licensed behavioral health clinics to provide "off-site" services in physician offices and other healthcare settings, removing a longstanding barrier to the integration of primary care and behavioral health. This new flexibility will be a consideration for the Practice Transformation Task Force in the development of integrated behavioral

health standards and will provide additional flexibility in our efforts to provide technical assistance for practice transformation in this important area.

- PA 14-217 which transfers responsibility for HIT and the Health Information Exchange (HIE) coordination to DSS will better enable the integration of SIM HIT initiatives, especially as it pertains to information exchange and analytics, and with DSS HIT initiatives within Medicaid such as the administration of the EHR incentive program.
- PA14-145 requires that consumers be informed of hospital facility fees, which will empower consumers to take cost into consideration when making decisions about where to go for care.
- New requirements for online license renewals for physicians, dentists, and APRNs is enabling us to integrate workforce survey questions so that we can more easily gather timely information about capacity distribution and changes in provider capabilities (e.g., EHR adoption, extended hours, etc.). DPH and the PMO are currently developing physician survey questions. PMO workforce analytic resources will enable the analysis of this data to inform our primary care investments and track progress over time.

During the Model Test, the state is committed to continuing to leverage its statutory and regulatory authority to influence the structure and performance of the state's healthcare system to support the aims of SIM. The following policy actions are planned or under consideration:

1) Amending insurance regulations to enable health plans to provide consumers with provider quality and cost information so that they can make informed decisions regarding high value care and to enable health plans to establish tiered networks based on provider value. This focus on performance transparency is an essential companions to VBID reforms and insurance design changes that make consumers more price sensitive;

2) Including VBID in the next procurement of Qualified Health Plans (effective with the 2016 benefit year) and establishing plan designs to encourage integration of behavioral and oral health, by Access Health CT pending approval by its board. This will contribute to our overall efforts to accelerate VBID penetration.

3) Reviewing same day service barriers, such as coverage limitations that prohibit reimbursement for medical and behavioral health services provided on the same day, which helps to enable integrated care; and

4) Using loan forgiveness programs to support the retention of residents in primary care. This would better enable the state to incentive primary care retention in primary care shortage areas.

V. Health Information Technology

HIT and HIEs have the potential to accelerate improvements in population health and innovations in healthcare delivery and payment reform, if positioned and leveraged in a meaningful way. To achieve the full potential of health system transformation, CT payers and providers will need to deploy a wide range of HIT capabilities, including data analytics, health information exchanges and care management tools. CT's Model Test seeks to provide HIT targeted solutions to assist implementation of each component of the proposal.

***Current State of HIT Adoption*:** As of May 2014, the state has received over $260 million through the EHR incentive program. Over 5,300 providers and all hospitals have received payments for adoption of EHRs, of whom 60% have attested to achieving Meaningful Use Stage 1. The 2013 HIE evaluation found that 68-74% of physicians are either using EHRs or are in the process of implementing EHRs; 96% of pharmacies are able to process e-prescriptions; 62% of prescribers are e-prescribing; 63% of hospitals are sharing lab results electronically, and 50% of

independent labs are sending lab results electronically. Currently, CT does not have an operational statewide HIE.

Governance: Effective July 1, 2014, the role of HIT Coordinator and full responsibilities for HIT were transferred to DSS through legislative action. DSS will build upon the existing HIT Strategic and Operational Plan, and recommendations from the technology work group on adoption of industry standards for data exchange; efficient and effective data sharing; person-centric focus; interoperability, integration and an open architecture; and secure data exchange.

DSS and the PMO will establish a HIT Council, including health and human service delivery agencies, providers, health plans and advocates, to participate in a one-year planning process. The planning process will result in an update of the three-year HIT strategic plan by August 2015 to incorporate Model Test needs. In the final year of the Model Test, the HIT plan will be updated again to reflect the changes within and evolved needs of the state as a result of implementing the Model Test and related activities. The HIT Council will be chaired by the Commissioner of DSS and facilitated by the HIT Coordinator, who will report to the Steering Committee on a quarterly basis. DSS and PMO will work closely together during the planning process and the Model Test implementation to coordinate efforts across programs, ensuring that all HIT assets are used optimally and any redundancies are identified early and avoided.

Policy: CT will execute the Model Test in the context of several ongoing transformational initiatives, such as the APCD, which will help guide and support the Model Test innovations. The Model Test will promote use of HIT and data analytics through its healthcare delivery system and payment reforms, but also statewide through a number of data-related policy levers needed for implementation of the Model Test: 1) the PMO, with guidance from the HIT Coordinator, will finalize a standard Data-Use and Reciprocal Support Agreement across

agencies and public-private enterprises to support data sharing and analyses; 2) all agencies/organizations participating in the Model Test will be asked to deploy edge-servers to index clinical and other health databases to support care delivery and analytics; and 3) all stakeholders, including payers, will be asked to make relevant data available for population-based analytics to help identify groups that can benefit from intensive clinical and community-based services.

Infrastructure: CT's overall HIT/HIE strategies aim to move the state from simply identifying and integrating available data to using such data and analytical tools to drive transformational change. Investments in these areas support **increased communication between providers, care coordination and integration across settings, population health assessments, improved care delivery and quality measurement and reporting**. Several existing HIT assets will support the quality data infrastructure that is essential for enhanced care delivery and payment reform, including: 1) standards based Health Provider Directory; 2) Enterprise Master Patient Index; 3) Health Information Service Provider service for Direct Messaging (DM); and 4) APCD. These assets are also building blocks for operating a statewide HIE, and with exception of the APCD, managed by DSS. The Model Test will support additional HIT and data analytic related infrastructure needs, including the following:

Consent registries: DSS will expand procurement for a consent registry that can be queried by Model Test participants in order to assess consumer consent status with respect to sharing of information. State bond funds have already supported core procurement of the registry.

Direct Messaging (DM): DSS is promoting the use of DM protocols to send messages between providers and/or systems, allowing secure exchange of clinical documents, such as discharge summaries, orders, and continuity of care documents. Additionally, DM can be used to generate

health alerts and reminders to improve care, especially for patients with chronic conditions. As of January 2015, most certified EHRs will be enabled with DM. Model Test funds will be used to provide DM addresses to providers that are not eligible for the CMS EHR incentive program, including behavioral health, long-term care, and home-health agencies.

Quality measurement: DSS will use Quality Reporting Document Architecture Category III and Category I standards for receiving eClinical Quality Measures (eCQMs) as one option in the EHR incentive program. With respect to the Model Test, this mechanism will be repurposed to help collect the quality measures recommended by the Quality Council and produce the cross-payer provider performance scorecard.

Expanded uptake of Personal Health Records (PHRs): DSS is working with CMS to initiate a project to provide PHRs to all Medicaid beneficiaries. The same PHR will be made available to commercial and Medicare beneficiaries who do not otherwise have access to a PHR.

Promoting access to data and analytics: DSS will create provider, organization, and state-level data reports enabled by edge-server based indexing technology that allows both large and small providers to access data and analytics equally, irrespective of resource constraints. These reports will improve healthcare delivery interventions, such as identifying populations in need of intensive services, as well as monitoring and evaluation. Existing state bond funding and CMS funding will jointly support the license for this technology and development costs, which will be supplemented by Model Test funding in Years 3 and 4.

The SIM PMO and its sister agencies will ensure that signing a Data-Use and Reciprocal Support Agreements (DURSA) is a condition for participation in SIM, for example, as a requirement for participation in the Medicaid QISSP, receipt of SIM-funded practice transformation support services, or participation with the consent registry. Consequently, we will

have the means to require that every provider participating in SIM allows indexing of data for analysis and aggregation. A DURSA was completed in 2009 by DSS (supported by a CMS transformation grant), which was executed by 3-FQHCs and one hospital. This agreement will be used as a starting point for any future work, as this approach will save the SIM staff time and accelerate our timeframe for making data driven decision making operational.

The use of edge servers allows for data analysis without having to move and secure these large datasets. Additionally, health plans and most stakeholders often worry about security and privacy, this allows them to remain in total control of their data, with complete knowledge that no copies of their data are being analyzed and reviewed. Lastly, this allows for the reports to run against the most updated information in local provider databases and clinical systems.

SIM funds will enhance existing HIT capabilities by supplementing existing funds to increase capacity and procure the following: 1) disease registries to support population health planning analyses and interventions; 2) mobile medical applications for improving care management; and 3) certified technologies for providers, using the Software-As-A-Service model, that do not have access to federal funding targeted for increasing HIT adoption. All existing state HIT assets will be available for the Model Test initiative for re-use through a shared cost arrangement. All HIT solutions are scalable and ready to be deployed within an enterprise.

Technical Assistance: HIT technical assistance (TA) will be provided by the HIT Coordinator and staff across the range of Model Test initiatives, particularly for AMH Glide Path and CCIP participants. In addition to general TA, this group also conducts outreach and provides education about DM, meaningful use measures, and quality improvement as it relates to eCQMs.

Alignment with statewide or regional HIE efforts to expand the availability and interoperability of health information:

All HIT activities funded by the SIM initiative other than the disease registry and the consent registry are currently in place. The state's investment in enterprise solutions are being leveraged for the SIM activities, and the costs have been allocated in proportion to the additional lives that will be added to the existing services. For example, we estimate that we will add about two million entities into our Enterprise Master Patient Index (EMPI) via the SIM initiative. Hence, associated costs have been attributed to SIM and not the total cost of the EMPI solution. Effective July 1, 2014 the responsibilities for HIT/HIE were transferred to the Department of Social Services (DSS) via Bill 5597 as was the role of HIT Coordinator. DSS has planned a set of six-meetings beginning on Sept. 17, 2014 with seven Commissioners and other senior government officials to review the existing HIT Strategic and Operational Plan and the recommendations of the technology work group to adopt industry standards for data exchange, and to establish a data Governance structure. The recommendations of the technology work group are centered on the following components:

- promote reusable components through standard interfaces and modularity,
- promote efficient and effective data sharing to meet stakeholders' needs,
- provide a person-centric focus,
- promote interoperability,
- integration and an open architecture, and
- promote secure data exchange.

After the conclusion of these meeting, the state will establish the next steps as well as a sustainability plan for the HIT/HIE going forward.

VI. Stakeholder Engagement

CT has established a governance structure that includes a broad range of stakeholders with direct and ongoing involvement in SIM design, implementation and evaluation. The governance structure includes the following:

Healthcare Innovation Steering Committee: This advisory Steering Committee is chaired by Lieutenant Governor and is responsible for providing overall oversight of the Innovation Plan and Model Test. Participants include private foundations; consumer advocates; representatives of hospitals, Advanced Networks, home health, physicians and APRNs; health plans; and employers. Additionally, the Comptroller's office is included as well as line agency Commissioners with responsibility for public health, Medicaid, behavioral health, health insurance exchange, APCD, and child welfare. The Steering Committee facilitates ongoing alignment of payment reforms through the use its ad hoc Finance Work Group, including all major health plans. The Steering Committee will designate a multi-payer Rapid Response Team to work directly with our evaluator to review and respond to information regarding pace and performance of our reforms.

Consumer Advisory Board (CAB): A 16 member independent consumer advisory board provides advice and guidance directly to the Steering Committee (on which it has a seat) and the PMO. The CAB is racially and ethnically diverse, with members involved in advocacy and community development, health services, and housing.

SIM Work Groups: A number of Councils and Task Forces have been established to undertake detailed design and oversight across a range of areas including Practice Transformation, Quality, Equity and Access, HIT, and Workforce Development. There are four broad categories of balanced representation on workgroups: consumer/advocate, payer, provider, and state agency.

Each workgroup charter requires a plan for stakeholder engagement to ensure that additional stakeholders are consulted on the development of specific work products.

Medical Assistance Program Oversight Council (MAPOC): CT law established the MAPOC as the legislative oversight body for the Medicaid/CHIP programs. The MAPOC will designate a committee to review and comment on each aspect of the design of the Medicaid QISSP, including the establishment of consumer protections and implementation activities. Committee membership will be supplemented by members of the Steering Committee and CAB. Additionally, MAPOC will designate up to two members to participate in each SIM work group.

***Consumer Engagement*:** Connecticut began the initial planning process for the Connecticut Healthcare Innovation Plan in 2013. During the summer of 2013, a number of workgroups were formed to develop the basis of our original plan. While a few consumer advocates were members of these workgroups, there were not any on the Steering Committee. In response to concerns raised by consumer advocates, two representatives were added to the steering committee in November 2013. In December, we submitted this Plan.

Beginning in January of this year, the SIM PMO began in earnest to implement a governance structure to oversee the implementation of Connecticut's Healthcare Innovation Plan. One of our chief aims was to expand the array of consumer advocates participating in our Steering Committee and new work groups. In addition, in February we re-established a dormant CAB formerly charged with other duties, which is now charged with advising the state on SIM implementation. Among the initial topics for the CAB's deliberation was achieving consumer advocate representation throughout the SIM governance structure. In a meeting on January 27, consumer advocates recommended that all work groups have at least 51% consumer advocate representation. The CAB considered this recommendation in its February meeting and instead

opted for the principle of balanced and proportional representation. This principle is reflected in the Guidelines for establishing work groups that was approved by the Healthcare Innovation Steering Committee in its February meeting.[1]

The CAB also advised the PMO as to the process for recruiting consumer advocates with the goal of enlisting a broader and more diverse array of consumer advocates. The CAB recommended a web-based candidate solicitation and worked with the PMO on the design and development of the solicitation content. The call for volunteers was disseminated widely and the process remained open for several weeks. The CAB was charged with reviewing all consumer advocate representatives, which they did through a careful deliberative process over the course of several weeks.

The CAB recommended and Lt Governor Wyman appointed three additional consumer advocates for the Steering Committee, one of whom was a member of the CAB and thus could serve as the liaison between the CAB and Steering Committee. This brought the number of consumer advocates on the Steering Committee up to a total of seven, or more than 25% of the total membership.

The CAB made recommendations to the Steering Committee for additional appointments to the CAB and initial appointments to the work groups. The Steering Committee completed its review and approval of all the proposed candidates on April 22, 2014. In the end, 4 additional consumer advocates were appointed to the CAB and 20 consumer advocates were appointed to

[1] http://www.healthreform.ct.gov/ohri/lib/ohri/sim/steering_committee/2014-02-18/sim_workgroup_composition_guidelines_02182014_final.pdf.

the Practice Transformation (7), Quality (6) and Equity and Access Councils (7). In total, there are currently more than 40 consumer advocates participating in SIM governance.

Although there are some advocates who continue to question the independence of the consumer advocates who participate in the SIM governance structure, we note that many of those represented in SIM governance today were signatories on past letters of opposition to SIM or its stakeholder engagement process. Moreover, members of the CAB, Steering Committee and work groups retain their independence as evidenced by the most recent letter of September 12, which included several signatories from these bodies, objecting to the pace of Medicaid participation in our proposed reforms.

In June, we experienced some turbulence in our planning when the Department of Social Services (Connecticut's Medicaid agency) presented specific details about the nature, scope and timing of Medicaid's participation in care delivery and payment reforms. A number of advocates had expected that Medicaid would participate many years out, after the benefits and risks of the value-based payment models was better established.

The state met with advocates and engaged in a discussion about the significant benefits that would likely accrue to Medicaid beneficiaries from early participation, and the value to the health care system as a whole. DSS and the SIM PMO emphasized the important role that Medicaid can play in influencing the capabilities of these newly emerging health systems, especially as it relates to health equity, social determinants and community integration. We also worked with advocates to refine our assurances related to under-service safeguards. Finally, we engaged the legislative leadership and advocates with respect to the role of the longstanding council for Medicaid oversight, the Medical Assistance Program Oversight Council (MAPOC). We worked together to devise a strategy whereby consumer advocates with SIM expertise would

participate in the MAPOC planning process as it relates to the Medicaid Quality Improvement and Shared Savings Program via its Care Management Committee, a committee composed of a diverse array of Medicaid stakeholders that includes several of the signatories to the September 12th letter to CMMI. Conversely, the MAPOC agreed to designate up to two of its members to participate in each of the SIM work groups.

In the end, many advocates, including a number who were initially opposed to early Medicaid participation, elected to support our proposed plan. They recognized the significance of the assurances and safeguards that were put into place, as well as the effort to integrate Medicaid and SIM planning, to the benefit of both programs. In recognition of the new processes that had been put into place, and after careful review of our grant application, the Consumer Advisory Board voted to provide a letter of support.

The CAB will continue to meet as we proceed with the implementation of the program. And the State is hiring a full-time coordinator to work with the CAB to implement our plans. The CAB has identified three areas of special concern that they will explore more fully: Chronic Diseases, Behavioral Health and Health Equity. We also plan to use learning communities, expert panels, and focus groups to identify and inform the process. In addition, we are planning listening sessions around the state to get input and feedback from consumers. As we identify new issues or concerns, it is very important that Connecticut continues to use vital consumer input as part of the healthcare innovation process.

Finally, the PMO and the CAB will support **consumer engagement** that meaningfully integrates consumer perspective and provides outreach and education for consumers about how innovation will change their experience of healthcare. Programmatic activities include consumer-led learning collaboratives, issue-driven focus groups, and targeted communications. Consumer

outreach will leverage the extensive regional network of our state's navigators and in-person assistors that enabled the state to double its enrollment goal in Access Health CT.

***Provider Engagement*:** The PMO's **provider engagement** activities have included a wide variety of providers in the development of the Model Test, including members of the CT State Medical Society, CT Chapter of the College of Physicians, CT Academy of Family Physicians, Community Health Center Association of CT, CT Chapter of the American Academy of Pediatrics, CT Hospital Association, the CT Association for Healthcare at Home and members of the LTSS community. More than fifty providers and trade associations are engaged in the SIM governance structure, including the MAPOC and its committees.

Providers have identified challenges or barriers to the success of the care delivery and payment reforms. Physicians note that there remains among many physicians a lack of knowledge about the reforms, or skepticism that such reforms will achieve promised improvements in quality, cost or satisfaction with the practice of primary care medicine. Unaddressed this may diminish physicians' willingness to participate in offered practice transformations support services or to participate with the Advanced Networks that are already involved in such reforms. Similarly, widespread reports nationally and in Connecticut regarding physician "burn out" will reduce participation or have a long term effect on primary care capacity.

The SIM PMO is partnering with physicians who are engaged in the SIM governance structure to undertake an extensive campaign to raise physician awareness and, importantly, to participate in forums that allow physicians to directly engage on the issues that cause them greatest concerns. We will do this work in collaboration with the various professional associations including the CT State Medical Society, CT Chapter of the American College of

Physicians, CT Academy of Family Physicians, and the CT Chapter of the Academy of Pediatrics.

In addition, the state is preparing to undertake a state funded pilot of its AMH Glide Path program in order to test the standards and methods that will be employed on a statewide scale under SIM. We believe that our transformation methods will be as important as the standards that we adopt. The methods must deliver greater efficiency, a more meaningful clinician experience, and greater freedom from avoidable administrative burden. Our proposed pilot will test transformation methods, allowing for flexibility in the application of these methods so that participating practices can help us to identify the optimal approach.

In summary, the pilot will enable us to:

- Test program administration such as methods of practice recruitment, criteria for participation, and progress monitoring and make course corrections before we scale up with a substantially larger number of practices and additional vendors in the last quarter of 2015.
- Test different methods of transformation (e.g., a clinical micro-systems approach to practice assessment, use of tech enablers, etc.) before finalizing our statewide strategy.
- Assess and optimize impact on physician experience…if satisfaction with practice does not improve, expansion will be challenging.
- Recruit practices to champion the value of SIM AMH transformation support, which will support practice recruitment later in the year.

We are also challenged by the high percentage of independent physicians in 2-4 person size groups and not in larger practices/networks and a lower percentage of these independent physicians in various risk-sharing or alternative payment models. The Connecticut State Medical Society is directly addressing this issue by providing an ACO options and the SIM practice

transformation support may be available for these providers. Our efforts at quality measure alignment should also make participation more efficient and practicable for these smaller scale arrangements.

Finally, Connecticut's FQHCs have expressed special challenges with building the data and analytic infrastructure necessary to support high performance in a quality and cost accountable environment. Moreover, they believe that they need support in develop continuous quality improvement process that will enable them to make progress as performance improvement opportunities are identified. Our Community and Clinical Integration Program and its associated Learning Collaborative will pay special attention to overcoming these challenges in the support they provide to the FQCH community participating in the Medicaid QISSP.

Payer Engagement: All of CT's health plan**s** have provided input into the Model Test and all have expressed support for the outlined reforms. Notably, health plans agreed to a broad-based annual assessment of $3.2 million in support of the PMO. **Health plans are involved in all aspects of planning and oversight for the proposed reforms.** In addition to representation on the Steering Committee, all health plans with more than 5% market share participate on the Practice Transformation, Quality, and Equity and Access work groups.

All of Connecticut's major commercial health plans participate in the SIM Healthcare Innovation Steering Committee and also continue to be actively engaged in the Quality Council, the Equity and Access Council, and the Practice Transformation Task Force. Anthem representatives actively participate in all of those forums. Anthem is the largest carrier in the State of Connecticut and an administrator of the Connecticut State Employee and Retiree Healthcare Plan.

Anthem will participate in our proposed efforts in several ways. First, Anthem has already begun to change its relationships with providers, moving to a collaborative model where provider organizations are rewarded based on quality and cost and given tools the tools and information required to be successful in a value based payment environment. Specifically, Anthem has entered into shared savings models where provider organizations are allowed to share in a portion of the savings (e.g., actual total costs for providing care to the defined population are less than projected total costs) provided they meet the quality threshold. In addition, the percentage of savings providers are eligible to receive, up to cap, increases as performance against the quality metrics increases.

In addition to shared savings opportunities, Anthem pays clinical coordination fees to participating groups for their defined population to provide non FFS payments that can be used to support a variety of activities critical to the successful adoption of a proactive, coordinated, care model. Currently, Anthem has arrangements with provider organizations that cover 56% of its primary care physicians in the State of Connecticut. These organizations include hospital owned physician groups, large independent physician groups as well as some smaller medical practices. The common thread is a foundation of primary care and a commitment to adopt patient centered care models. Anthem's model aligns with our proposed efforts and Anthem has committed to continue and expand its efforts.

Second, as active participants in the Quality Council, all of Connecticut's major commercial health plans, including Anthem, strongly support the development of a common set of metrics for all payers to use with Advanced Networks participating in shared savings programs and other providers who are eligible to receive payment rewards. In short, Anthem would replace the existing quality metrics it uses in its shared savings program (described above) with the all payer

metrics developed to support Connecticut's proposed efforts. Anthem understands that alignment of quality metrics across payers will help providers focus on those metrics that are most meaningful and impactful, increasing the likelihood that they will be able to improve performance against these metrics over time.

Third, Anthem will continue to provide its participating providers with resources and tools design to support their successful transformation to a proactive and coordinated care model in a way that augments any resources or tools provided on an all-payer basis should the State receive the Round 2 test grant

Finally, in its application for the Round 2 test grant, the State presented its plan to undertake a comparative effectiveness study of VBID plans and Accountable Care Organizations. The goal of the study is to evaluate the effectiveness of VBID and value-based payment models alone and in concert with one another to see which is more effective and whether synergies can be achieved by offering the member incentive (VBID) and provider incentives in combination. Anthem and its analytic team at HealthCore, a research subsidiary of Anthem's parent corporation WellPoint, have recently committed resources to begin the study immediately with the State Employee and Retiree Healthcare Plan and several control groups. Should the State receive the Round 2 test grant the study could then be expanded to other populations.

Employer engagement: Employers are fundamental to achieving care delivery and payment reforms and the SIM governance structure and programmatic activities establish formal mechanisms for on-going employer engagement. Notably, representatives from the state's largest employers and early adopters of value based insurance design (VBID), a critical component of the Model Test, are actively committed to the implementation of the SIM. These employers are members of the Steering Committee, and participate in workgroups charged with design and

implementation of the Model Test. The PMO will convene an annual Innovators Conference for all stakeholders involved in SIM governance and workgroups.

VII. Quality Measurement Alignment

All of CT's major health plans and Medicaid have committed to quality measure alignment including the following: 1) a core quality measurement set for primary care providers, select specialists, and hospitals; 2) a common cross-payer measure of care experience tied to value based payment; and 3) a common provider scorecard. Health plans recognize that this unified approach will reduce the administrative burden on providers, enabling them to organize their performance improvement efforts around common expectations, rather than the fragmented business rules and reporting requirements that exist today. It will also provide consistent incentives, standardized reporting, and multi-payer clinical reports on quality and cost metrics.

Quality, care experience and cost measures will be developed by the Quality Council, which is comprised of the five major health plans, one large employer, six consumer advocates, three state agencies, six practicing physicians, one FQHC and one hospital. Health plan representatives include medical directors, statisticians and measurement experts. The Council will propose a core set of measures for use in the assessment of primary care, specialty care, including behavioral and oral health, and hospital provider performance and will reassess measures on a regular basis to identify gaps and incorporate new national measures to keep pace with clinical and technological practice. The Council will begin meeting in July 2014 and will complete its recommendations regarding primary care by December 2014. Health plans will modify systems and contracts in 2015 and implement the new measurement set and scorecard in 2016. Measures of specialty care and hospital performance will be recommended by the Council in 2015 with

implementation scheduled for the 2017 measurement year. The state will compute and post cross-payer provider performance data for consumer and provider review.

Quality Measures: The Quality Council will prioritize measures that are recommended by CMMI, align with existing Medicare performance measurement initiatives, and established or endorsed by the Healthcare Effectiveness Data and Information Set (HEDIS), National Quality Foundation, Agency for Healthcare Research and Quality, or U.S. Preventive Services Task Force. The following measures may be considered:

Care Experience: getting timely care, appointments, and information; how well your doctors communicate; patients' rating of doctor, access to specialists; health promotion and education; shared decision making; health status/functional status

Prevention/Screening: well child visits, mammograms (women > 50), colorectal cancer screening (adults > 50), influenza immunization, pneumococcal vaccination, hypertension (HTN), depression, fall risk and addiction screening, tobacco use assessment and cessation intervention, weight screening and follow-up.

Chronic Illness Management: diabetes, asthma, hypertension, hyperlipidemia, congestive heart failure, coronary artery disease, chronic obstructive pulmonary disease, chronic pain, sickle cell

Care Coordination/Patient Safety: hospitalizations for ambulatory care sensitive conditions, readmissions for avoidable complications, medication reconciliation, asthma ED visits, hospitalization due to falls

Resource Efficiency: Duplicative testing, generic prescribing, use of lower-cost providers.

Health equity gaps for each measure will be considered for inclusion in the core quality measurement set.

Care Experience Survey: The most important means to improve consumer experience is to measure care experience, publish results, and link results to payment. As part of our Model Test, all health plans and Medicaid will require a care experience survey for providers participating in SSP arrangements as of the 2016 contract year, using a survey tool recommended by the Quality Council. The survey results will be used to assess the performance of each provider for the purpose of determining whether and to what extent a provider qualifies for shared savings. Similar to the provider performance scorecard, the state will post cross-payer care experience survey results to ensure transparency for consumers.

The PMO will contract with a vendor for the administration of care experience surveys with sufficient statistical reliability and validity at the level of the Advanced Network or FQHC to support the inclusion of care experience scores in the performance scorecard and as a factor in calculating SSP rewards. The sample will be drawn from attributed patients of Advanced Networks and FQHCs participating in SSP. This represents the first effort among payers to use cross-payer pooled performance data. During the Model Test, the vendor will oversample for Medicaid recipients in order to assess the extent to which there are health equity gaps in care experience, care experience survey results will be included in provider performance scorecard tied to SSP calculations.

Providers will have the option to arrange and finance the care experience survey themselves, provided they use the recommended survey tool and methods. For the first two years of the Model Test, the PMO will co-source the conduct of the survey free of charge on behalf of those providers that do not wish to undertake the survey themselves. Combining the purchasing power of participating providers will significantly reduce the cost per completed survey. By the third year of the Model Test, providers will be charged a fee sufficient to cover the administration and

conduct of the survey. The state will explore with CMMI the option of combining this survey with that of Medicare's ACO survey.

Funding the administration and conduct of the care experience survey:

As noted above, all of Connecticut's payers will require a statistically valid and sufficient consumer survey as a condition for participating in a value-based payment arrangement as of the 2016 contract year, using a care experience survey tool recommended by the Quality Council and approved by the Healthcare Innovation Steering Committee. The results of such survey will be used to assess the performance of each Advanced Network or FQHC (collectively referred to here as provider organizations) for the purpose of determining qualification to receive shared savings. The sample will be drawn from each entity's attributed patients, without regard to payer or source of coverage, except that in the initial years, we will oversample for Medicaid in order to quantify the Medicaid/commercial health equity gap as it pertains to care experience.

The per provider organization cost of administering a statistically sufficient CAHPS survey (assuming that is the measure selected) depends on the number of primary care clinicians employed by or affiliated with the provider organization for the purpose of performance accountability and the methods that are used. See Table 3 for NCQA's information detailing the sample size required as it relates to the number of primary care clinicians.

Table 3

Sample Sizes

Number of Clinicians	Sample Size
1	128
2-3	171
4-9	343
10-13	429
14-19	500
20-28	643
29 or more	686

Table 4 presents the approximate cost per provider organization based on the required sample size, using an NCQA certified vendor and methods. We anticipate that nearly all of these provider organizations are comprised of greater than 29 clinicians placing them in the largest survey class.

Table 4

Care Experience Survey		
Cost per provider organization		
Sample Size	Low Range ($5/completed)	High Range ($10/completed)
128	$ 640	$ 1,280
171	$ 855	$ 1,710
343	$ 1,715	$ 3,430
429	$ 2,145	$ 4,290
500	$ 2,500	$ 5,000
643	$ 3,215	$ 6,430
686	$ 3,430	$ 6,860

We assumed that we would survey 45 provider organizations in 2016 (for 2015 baseline) and 45 provider organizations in 2017 (for 2016 performance year at $6860 per provider). This is double the above "low range" cost, which provides for Medicaid over-sampling. We assume that the annual ongoing fee charged to entities for statewide administration of their survey would remain at this level as long as we continue to include Medicaid over-sampling.

For the first two years (2015 baseline, and 2016 performance year), the state has proposed to use SIM funding to subsidize the cost of the survey. The PMO will co-source the conduct of the survey on behalf of all payers and provider organization participating in SSP arrangements. We believe that combining the purchasing power in this way will reduce the cost per completed survey. As of the 2017 performance year, each provider organization will have the option to arrange for and finance the care experience survey themselves, provided they use the survey tool and methods approved by the Steering Committee, and to have their performance reported to the PMO and each payer.

Pending review of our proposed approach with the Quality Council, the PMO intends to co-source the conduct of the survey using an NCQA certified vendor and methods. Beginning with the 2017 performance year, the vendor will be expected to administer the collection of provider organization fees to support the administration of the survey in early 2018. In the third quarter of 2017, the PMO will solicit from payers a list of provider organizations participating in SSP arrangements. The vendor will contact each provider organization giving them the option of participating in the PMO administered survey process. The provider organization will be asked to pay a fee and sign an agreement. The vendor will send the signed agreements to each payer in the fourth quarter of 2017 soliciting a list of attributed beneficiaries. In the first quarter of 2018, the vendor will undertake the survey, compile results into a report, and provide the report to the

PMO and each payer for use in the administration of their shared savings payment arrangements. Provider organizations that do not enter into an agreement with the PMO's vendor will be required by payers to provide a qualifying survey in order to receive a shared savings distribution.

VIII. Monitoring and Evaluation Plan

Overall Approach: We will monitor and report on the impact of the Model Test on 1) population health; 2) health care quality; and 3) per capita healthcare spending. Our evaluation approach includes the 1) collection of real-time data to promote and support continuous quality improvement; 2) use of advanced statistical methods to analyze complex data and account for nonrandomized designs when conducting assessments of specific innovations, such as VBID; and 3) collection of qualitative data to better understand the context of reform efforts. Data on Model Test targets will be compiled quarterly and reported to the PMO, Rapid Response Team and CMMI at specified intervals, to facilitate rapid-cycle evaluation of reform efforts and identify areas for mid-course corrections.

Reports: The team will prepare a *Dashboard* that presents summaries of a core set of measures, corresponding to Model Test targets, to 1) monitor the pace of implementation and performance of key program initiatives; and 2) provide data on changes in health outcomes and health spending to inform short time-cycle program adjustments. Dashboard measures will be refined in conjunction with CMS during pre-implementation.

Strengthening Population Health: The team will report to CMMI about progress developing the Population Health Plan, including 1) identifying priorities, barriers and interventions; 2) completing a population health assessment; 3) implementation of a PSC demonstration; and 4) finalization of the Health Enhancement Community (HEC) design. The Dashboard will include

measures for statewide population health targets contained in the states' Healthy CT 2020 plan including tobacco use, obesity, and diabetes prevalence. New measures will be selected that align with the priority areas identified in the Population Health Plan.

The plan for improving population health will utilize and build upon the DPH's recent State Health Assessment, State Health Improvement Plan (Healthy Connecticut 2020) and the state Chronic Disease Prevention Plan. This revised plan will be completed during Years 1 and 2 of the Test Grant. Three of the measures presented in Table 6 below should be considered examples of population health measures that we will monitor over the course of the project: Percent of adults with a regular source of care; frequency of well-child visits, especially for at-risk populations; and premature death due to cardiovascular disease among adults. The measures listed in Table 6 are all derived from population-level datasets (e.g. BRFSS, Hospital and ED discharge data, Vital Statistics).

In addition, the State Chronic Disease Plan has established population measures with baselines and targets for obesity, tobacco and diabetes, which are delineated in Table 5 below. These measures will serve as a baseline for anticipated interventions targeting these three conditions.

Table 5

Category/Measure	Base	2016	2017	2018	2019	2020
Percent of adults who are obese	24.50%	23.65%	23.48%	23.30%	23.13%	22.95%
Percent of children who are obese	18.80%	18.15%	18.03%	17.90%	17.78%	17.65%
Percent of children in low-income households who are obese	38.00%	36.65%	36.40%	36.10%	35.83%	35.55%
Percent of adults who currently smoke	17.10%	15.60%	15.30%	15.00%	14.70%	14.40%
Percent low income adults who smoke	25.00%	23.58%	23.30%	23.00%	22.70%	22.43%
Percent of youth (high school) who currently smoke	14.00%	13.28%	13.14%	13.00%	12.85%	12.72%
Percent of adults with diabetes	8.50%	8.14%	8.07%	8.00%	7.93%	7.86%
Percent of adults with diabetes – low income	14.30%	12.65%	12.31%	12.00%	11.65%	11.32%

Additional population health priorities, measures and targets (e.g. child wellness, vaccines and infant mortality), will be identified by the Population Health Council during the development of the population health plan in Year 2 of the Test Grant. Baselines for population health measures will include overall population totals and stratified totals by age, race and ethnicity, and payer (Medicare, Medicaid, commercially insured), all of which are available in the source data (e.g., HEDIS, BRFSS, Vital Statistics Registry).

Transforming the Health Care Delivery System: We will monitor the pace and impact of delivery system changes by tracking policy and structure changes, such as the adoption by practice groups of HIT and team-based care, and measures of potential impact, such as the

percentage of residents attributed to a PCP that are reimbursed under a SSP.

Pace:

Major operational plan milestones include Medicaid Quality Improvement and Shared Savings Program (Medicaid QISSP) implementation, involvement in the Community and Clinical Integration program, percent of primary care providers and beneficiaries in shared savings programs (SSPs) and percent of employers adopting value based insurance designs (Table 1; Test Model submission and Tables 1-7 in Appendix C of this response).

As part of the Test Model evaluation process we will monitor the measures described in Appendix C, Tables 1 through 7. In addition, the differential adoption by practice groups of new benefit and payment models will allow rigorous assessments of, for example, the impact of employee benefit plans (e.g. VBID) and provider reimbursement (e.g. SSP) on care patterns, costs, and health outcomes. Assessment of the impact of different delivery, benefit, and payment models will require information on rates of adoption.

In anticipation of potential Model Test implementation, the evaluation team is conducting a state wide survey of 1,200 primary care and specialist physicians in Connecticut to assess the readiness of the physician workforce in the state to assume financial risk and provide services consistent with the advanced medical home model. Drs. Cleary and Aseltine have conducted numerous surveys of physicians and it is clear that many physicians are unaware of, or cannot report accurately about, the financial models under which they are reimbursed. The general problem of lack of awareness of financial arrangements is exacerbated by the fact that most physicians receive reimbursement from multiple health insurance plans, both public and private. Beneficiaries have difficulty reporting the type of insurance coverage they have, and have very little, if any, understanding of how their physician is reimbursed.

The SIM evaluation team is currently preparing to launch the physician survey. As of October 1 a data collection contractor had been selected. The survey instrument is being finalized and the sample is being prepared. The survey instrument will be reviewed by the Steering Committee on October 16, pretested during the last 2 weeks of October and moved into the field the first week of November. Data collection will continue through December with the results compiled and delivered to the State by January 15, 2015.

Thus to collect data that will allow us to assess the pace and impact of test model changes, we will use three general strategies. Each quarter we will elicit information on rates of participation available from the 5 major CT insurers, Medicare, and Medicaid (e.g., percent of primary care providers in shared savings arrangements). For some aspects of program pace (e.g., implementation of the Community and Clinical Integration Program), we will conduct quarterly surveys of the CT Advanced Networks (currently 17) and FQHCs. For those aspects of the program in which we elicit information about participation form the Advanced Networks, we also conduct a survey of a sample of 1,000 health care providers not in Advanced Networks. That information will allow us to determine the extent to which providers in the Advanced Networks are making changes that are greater than other providers in CT.

Survey strategy

When we have conducted national surveys of health care plans, we typically have surveyed both the Chief Medical Officer and the Lead Administrator. The major insurers have agreed to designate a contact person for providing information for the quarterly reports. To collect information from the Advanced Networks and in the annual survey of providers, we will identify a clinical and administrative head to provide the information required. The surveys of Advanced

Network representatives and non-affiliated providers will be conducted by mail with a telephone follow-up to non-responders. Survey development will include pilot testing to insure questions are clear and consistently understood. Data collection will be conducted by professional survey firms that will bid on specific projects and activities. The current CT physician survey is being conducted by the Center for Survey Research (CSR) at the University of Massachusetts-Boston. An example of another firm that we would solicit bids form is the Survey Research Center at the University of Michigan. Both are University based survey research organizations with the staff and resources to carry out all phases of multi-mode survey research and have significant experience conducting dual-language surveys, Spanish/English in particular. Drs. Aseltine and Cleary have extensive experience in working with both organizations on numerous large-scale projects.

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Performance:

Changes in the delivery system over the Model Test period are expected to allow the State to achieve the access and quality targets identified in Table 4. These quality targets for both the Medicare and non-Medicare populations are based on measures derived from three sources: Connecticut BRFSS data, HEDIS measures, and claims data from the CT Hospital Inpatient Discharge Database (HIDD) and APCD. Hospitalizations for ambulatory sensitive conditions using the AHRQ Prevention Quality Indicators will serve as a critical measure of quality. Baselines using 2012 data from the HIDD are presented in Appendix D separately among the Medicare, Medicaid, and privately insured populations, along with quality targets for each population over the course of the proposed grant. Projections in this table draw on the 2012 base rates for hospitalizations and assume a stable denominator over the duration of the Test Grant. Base rates will be recalculated with the most current data available at the beginning of the grant, and population totals will be monitored over the course of the grant and adjusted accordingly.

Available HEDIS measures for all CT health plans will be compiled after annual submission annually and used to measure performance in care delivery and to track changes associated with payment reform and practice transformation initiatives. When plans submit their HEDIS data to NCQA, they include the eligible population, the oversampling rate, the number of numerator events in the final sample, and various exclusions, as well as the rate (e.g. percent receiving LDL-C screening). In addition to examining plan specific changes, We will use these data to weight the performance indicators from each plan to develop a statewide estimate for individuals

in Medicare, a commercial health plan, or Medicaid. Managed care organizations in Connecticut are required by law to report HEDIS data, so coverage is excellent. We will use BRFSS data to estimate the proportion not in a health plan and estimate the bias for measures also assessed in the BRFSS."

Population denominators will be also be collected from payers at selected intervals.

Table 6

Category/Measure	Base	2016	2017	2018	2019	2020
% of adults w/ regular source of care	83.9	85.7	87.5	89.4	91.2	93.0
Risk - std. all condition readmissions	15.9	15.3	14.8	14.2	13.7	13.1
Amb Care Sensitive Cond Admissions	1448.7	1398.0	1347.3	1296.5	1245.8	1195.1
Children well-child visits for at-risk pop	62.8	64.1	65.3	66.6	67.8	69.1
Mammogram for women >50 last 2 years	83.9	84.7	85.4	86.2	87.0	87.7
Colorectal screening - adults aged 50+	75.7	77.2	78.8	80.3	81.9	83.6
Colorectal screening - Low income	64.9	65.6	66.2	66.9	67.5	68.2
Optimal diabetes care - 2+ annual Alc tests	72.9	74.3	75.7	77.1	78.6	80.1
ED use - asthma as primary dx (per 10k)	73.0	71.2	69.4	67.6	65.8	64.0
ED use - asthma as primary dx (Hispanics)	170.5	168.0	165.5	163.0	160.5	158.0
% of adults with HTN taking HTN meds	60.1	62.0	63.9	65.7	67.6	69.5
Premature death-CVD adults (per 100k)	889.0	819.2	749.4	679.6	609.8	540.0
Premature death-CVD black adults (/100k)	1737.6	1562.1	1386.6	1211.0	1035.5	860.0

Quality measures and targets related to hospitalizations will be calculated using the AHRQ Prevention Quality Indicators (PQIs), 14 measures of conditions managed in ambulatory settings. Additional measures and targets, including behavioral health and oral health are under review.

Connecticut Medicaid collects and reports a full array of quality measures across its clinical programs. With some notable exceptions, these measure sets are complete since the beginning of calendar year 2012, when the Department transitioned entirely to an administrative services model of care. These include an annual Consumer Assessment of Healthcare Providers and Systems surveys of both adult and child members, a complete panel of HEDIS and CHIPRA

measures, as well as several measures of special interest to the Department and its stakeholders. Examples of these 'home grown' measures are the incidence of sexually transmitted infections in males (not just in females, which is the HEDIS measure) and a more detailed measure of 30 day hospital readmissions which includes all ages and diagnoses. Connecticut Medicaid is participating in the Quality Council and intends to adjust its quality measures pending the recommendations of the SIM Quality Council and in consultation with the Medical Assistance Program Oversight Council's Care Management Committee.

Equity: A major goal of the Model Test is to improve equity in access and quality. We will monitor equity gaps for the core Dashboard measures and target selected areas for improvement.

Costs of Health Care: Major operational plan milestones include 1) Medicaid QISSP implementation, 2) percent increase in providers/beneficiaries in SSPs; 2) percent of employers adopting VBID; 3) percent of consumers with access to price information via performance scorecards. Additionally, the State has established the following PMPM cost targets:

Table 7

Cost (PMPM)	2014	2015	2016	2017	2018	2019	2020
ASO/Fully insured	$457	$478	$501	$525	$550	$576	$603
State employees w/o Medicare	$547	$573	$600	$629	$658	$690	$722
Medicare	$850	$887	$926	$966	$1,007	$1,051	$1,096
Medicaid/CHIP, incl. expansion	$390	$408	$426	$446	$466	$487	$509
Average	$515	$539	$565	$591	$619	$649	$679

Data Sources: CT has many existing data sources to support evaluation and monitoring, including the CT BRFSS data and claims data from CT's APCD, which will be used to monitor the extent to which CT is achieving annual quality, cost and population health targets. CT's

APCD includes eligibility data; medical, pharmacy, and dental claims; and provider information since 2008. For the 14 large primary care practice groups in CT (representing 65% of PCPs in the state and 55% of state employees) two large insurance plans have agreed to differentially assign 1) insurance design and 2) payment strategy, so that we can assess the independent and synergistic effects of benefit design and payment arrangements.

Collection of new data: We will compile or collect quantitative and qualitative data to supplement the BRFSS and APCD data. The evaluation team has extensive experience developing and administering patient, provider, and population surveys. To assess consumer experiences with care, we will use Consumer Assessment of Healthcare Providers and Systems (CAHPS) data which are collected annually from representative samples of Medicare beneficiaries, hospitalized patients, and individuals in accredited health plans. To enable generalization about ambulatory care experiences to the CT population as a whole, we will conduct a statewide survey about consumer engagement and care experiences that will include Medicaid and other individuals not in accredited health plans in Year 2. We will conduct a statewide survey of providers in Year 3 that will allow us to assess changes in barriers to system changes and provider activities and practice patterns assessed in a statewide survey of 1,200 CT physicians conducted in fall 2014. Finally, semi-structured interviews with key stakeholders will provide critical information on the pace of delivery system transformation, barriers to change, and changes in the ability to provide high quality, efficient care.

Focused Analyses of the Impact of Reform Efforts: The differential adoption by practice groups of new benefit and payment models will allow rigorous assessments of, for example, the impact of employee benefit plans (e.g. VBID) and provider reimbursement (e.g. SSP) on care patterns, costs, and health outcomes. Assessment of the impact of different delivery, benefit, and

payment models will use statistical methods that account for non-random assignment to conditions and the clustering of patients within sites and sites within larger organizations. For example, we will use hierarchical regression models to account for correlation among patients within clinics and allow for differential changes across sites and propensity score matching to account for non-random assignment. Changes in outcomes across groups of sites can be estimated using an interaction term between measurement period and groups (e.g. adopters vs. non-adopters of an innovation).

***Ability to provide current identifiable, individual Medicaid claims data to the federal evaluator/CMS*:**

Connecticut Medicaid has extremely strong analytic capacity and expertise. Since 2012, Connecticut Medicaid has had the benefit of a fully integrated set of claims data across all categories of Medicaid services. The Department's medical ASO, CHN, maintains this data within the Utilization & Cost Analyzer (UCA) system, an analytical and data discovery tool that includes Medicaid claims, member eligibility, and provider data. UCA utilizes QlikView software and is uploaded monthly with claims, member eligibility, and provider data directly from CHN's data warehouse specific to the Connecticut Medicaid program. The data warehouse is populated with data that is received from the Department and its claims processing partner, HP. UCA provides a simple, rapid, and comprehensive means of assessing medical cost and utilization trends in various cuts of the claims, member eligibility and provider data with multiple layers of drillable investigative analysis, down to the claim, member and provider level. The Department anticipates that the data extracts necessary to support the federal evaluation will be produced by CHN. As noted above, the Department will enter into data use agreements

(DUA) with CMS or the federal contractor for purposes of sharing the minimum necessary identifiable data.

Ability to provide individual-level commercial claims data to the federal evaluator/CMS:

The All-Payer Claims Database (APCD) that Access Health CT (AHCT) is developing will have commercial data with member identifiers. All of Connecticut's health plans have indicated their support for the APCD as evidenced in each of their letters of support for SIM. Moreover, they have all recently reaffirmed their commitment to use the APCD as the primary and preferred source for the production of commercial health plan data and reports to meet the needs of the state and federal evaluation of the SIM program.

The SIM PMO will convene a SIM Program Monitoring team comprised of APCD officials, participating health plans, and state and federal evaluators in order to further specify the requirements of the federal and state evaluations and to determine whether all required elements for the evaluation are addressed in the approved Data Submission Guidelines and, if not addressed, appropriate steps will be taken to modify these guidelines including necessary approvals. The SIM Program Monitoring Team will further determine the level of data identification necessary to achieve the purposes of the state and federal evaluations.

The APCD data infrastructure will be managed by an outside data and analytics vendor with capabilities of maintaining and operating a robust data ETL process, transformation of this data from various data submitters into an equivalent data base structure and maintain historical data of eligibility, medical and pharmacy claims, and provider information.

There will be two environments in this data infrastructure.

i. Production environment – will be used to generate healthcare costs and utilization reports on the web, to be primarily used and accessed by the data analytic vendor, and

ii. Managed Hosting environment – with an enclave style access management primarily for internal and external users, e.g., SIM analysts, CMS and the federal evaluator.

The Managed Hosting server will be accessible via secured VPN connectivity. Users will have access to permissible directories via a Data Enclave environment. The environment will be firewalled from outside intrusion, and is only accessible to authorized users. Researchers and analysts involved with SIM will have access to analytic tools in secure environment to work with the data, including such applications as SQL, SAS, and other applications. Data can be accessed to generate member and provider list for relevant ACOs and FQHCs; reports can be run for risk-adjusted costs and utilization reports by various participating entities; evaluate pre- and post-intervention effects due to SIM initiative; develop ID and Stratification based on clinical groupers for members in the ACO or FQHC groups; and, various other reports on claims-based compliance and other quality indicators.

The vendor for data intake and integration is targeted to be in place at the beginning of 4th quarter 2014. The timeline for data intake and integration are as follows:

Table 8

Activities	Target Date
1. Develop data intake infrastructure for commercial and public (Medicare) payers	12/15/2014
2. Test for stability and efficiency of data ETL process	1/15/2015
3. Receive and upload test data	1/31/2015
4. Data Quality validation a. Ensure files received from data submitters are accurate	2/15/2015

b. Ensure data contents from various files are accurate c. Ensure files are transmitted are complete – control total d. Ensure data files conform to general benchmarks	2/28/2015 3/15/2015 3/15/2015
5. Data warehouse completed and tested	4/15/2015
6. Historical data in-take	6/15/2015
7. Analytic environment tested	7/1/2015
8. Production Environment tested	7/15/2015
9. Production Environment deployed	8/1/2015

Ability to provide Medicare identifiers to the federal evaluator/CMS for beneficiaries affected by SIM:

The plan for Connecticut's APCD includes the collection of Medicare fee-for-service data from CMS. The data set will have Medicare beneficiaries' information with claims level details. If allowed by CMS, that data can be used to support SIM initiative. We intend to collect monthly files from CMS. If not available then we can at least collect information at quarterly time intervals. Part D of Medicare will also be available. As part of the collection effort, the APCD intends to collect Part C Medicare data as well from health insurance carriers. Data collected from Medicare program will be maintained in the same data infrastructure as discussed in 8(b) above. As such, the APCD will be a source of linked and de-duplicated individual claims level data, inclusive of Medicare.

Connecticut will compile and share information about the identity of the Advanced Networks and FQHCs that are participating in the MQISSP in each of the two waves and receiving AMH Glide Path and CCIP support. We believe that CSM would be the most reliable source of information about Medicare beneficiaries attributed to and benefiting from their

participation with these providers. We would request that CMS share information about Medicare attributed beneficiaries with the state evaluators to support our rapid cycle learning and evaluation.

Laws and/or regulations preventing the disclosure of necessary records or data to the federal contractor performing the evaluation of SIM:

Medicaid: Federal Medicaid law provides that state Medicaid agencies must restrict the use and disclosure of information concerning Medicaid applicants and recipients "to purposes directly connected with administration of the plan." 42 U.S.C. § 1396a(a)(7); 42 C.F.R. § 431.300(a). More specifically, the federal regulation defines "purposes directly related to plan administration" as including "(a) establishing eligibility; (b) determining the amount of medical assistance; (c) providing services for beneficiaries; and (d) conducting or assisting an investigation, prosecution or civil of criminal proceeding related to administration of the plan." 42 C.F.R. § 431.302.

State law, specifically section 17b-90(b) of the Connecticut General Statutes, similarly provides that, except for purposes directly connected with the administration of the Department of Social Services programs, disclosure of information about persons applying for or receiving assistance from the Department, or persons participating in the Department's programs, is prohibited. State regulations provide that "purposes directly connected with" the Department's programs includes "an audit or similar activity conducted in connection with the administration of the program by any governmental entity authorized by law to conduct such audit or activity." Section 1020.10 of the Uniform Policy Manual.

The Connecticut Department of Social Services will regard disclosure of necessary records or data to the federal contractor performing evaluation of SIM to be for purposes directly

connected with administration of the plan. Assuming the federal contractor has a business associate agreement with CMS, the Department will enter into data use agreements (DUA) with CMS or the federal contractor for purposes of data sharing. These DUAs will parallel those into which the Department has entered with CMS in support of data sharing for the Demonstration to Integrate Care for Medicare-Medicaid Enrollees.

APCD: APCD enabling legislation permits the sharing of de-identified, individual level data for commercial payers. Medicare data sharing will be governed by CMS rules particularly supporting CMMI funded demonstration projects. However, it does not permit the sharing of data on identifiable members to external entities such as state or federal agencies and their respective evaluators. The SIM PMO will convene a team comprised of APCD officials, participating health plans, and state and federal evaluators in order to further specify the requirements of the federal and state evaluations and to determine whether the purposes of the evaluation can be achieved with an individual level, de-identified data set or whether a limited data set with date of service and zip code will be required. If the latter is necessary to achieve the purpose of the evaluation, the state will propose legislation that will enable the APCD to share the limited data set for the purpose of the SIM evaluation. We anticipate that such legislation can be achieved by June of 2015. If a more complete set of identifiers is required, additional research will be necessary to determine whether an amendment to the APCD legislation would be sufficient for this purpose.

In summary, with respect to commercial data, Connecticut's APCD enabling legislation does not permit the sharing of data on identifiable members to external entities such as state or federal agencies and their respective evaluators. The state will propose legislation in the 2015 legislative session that will enable the APCD to share the limited data set with the federal and

state evaluation contractors for the narrow purpose of enabling the SIM evaluation. We anticipate that such legislation can be achieved by June of 2015. If the statutory language permitting the disclosure of identifiable data from the APCD to CMMI for the purposes of SIM evaluation is not successful, the SIM PMO will work with the individual commercial payers to provide for direct submission of the minimum identifiable dataset necessary to achieve the purposes of the evaluation. We are also prepared to directly engage self-funded employers to the extent that this is necessary to ensure authorization for the provision of necessary data. The proposed HIPAA rule change appears to resolve questions that emerged in our discussions with commercial payers as to the permissibility of such disclosures under HIPAA. There are no state laws that otherwise would prohibit their disclosure, other than potential limitations on the disclosure of behavioral health information (CGS 52-14 b, c, d, e and f), which we intend to address with the above referenced changes to the APCD enabling legislation.

General/HIPAA: SIM will be in compliance with the new HIPAA/HITECH rules effective September 22, 2014. We recognize that covered entities must bring all of their Business Associate Agreements ("BAAs") into compliance with the Rules and that the new Rules also apply this requirement to Business Associates' agreements with their covered subcontractors. While the Rules in some respects represent a major departure from the existing HIPAA and HITECH requirements, many of the new provisions accept without change the requirements that the HHS had previously proposed in the interim final HITECH Breach Notification Rule, in October 2009, and in the proposed Privacy, Security and Enforcement Rules updates in July 2010 (the "Interim Rules"). Entities that have aligned their practices with the Interim Rule will, therefore, have fewer changes to implement.

Cooperation with the contractor performing the federal evaluation:

The state will fully cooperate with the contractor performance the federal evaluation as described in our responses to 8(a-d) above. The state will provide informant in a timely manner that will allow CMS to review and comment on methods and results from the state evaluation before publication of results.

The SIM Evaluation Team is committed to meeting with CMS and its external evaluator and the SIM Rapid Response Team (see Project Narrative, Section VI) as frequently as is necessary to inform and monitor program implementation and to allow for external oversight and evaluation. Drs. Aseltine and Cleary and their project management teams will coordinate the quarterly reporting relevant to SIM program pace and performance monitoring and periodic outcome assessments and be responsible for meeting with the Steering Committee and federal evaluation contractor every other week for the first 6 months of the project, and monthly thereafter. Dr. Cleary and his team will coordinate and lead the meetings with the SIM Rapid Response Team on pace and performance monitoring, and Dr. Aseltine and his team will coordinate and lead the meetings with CMMI and/or the federal evaluation contractor. Meetings with CMS and the federal evaluation contractor will also provide opportunities for CMS to review and comment on methods and results from the state evaluation prior to publication and dissemination of findings.

IX. Alignment with State and Federal Innovation

The state is currently engaged in a range of innovations that complement the Model Test: Integrated Care Demonstration for Medicare/Medicaid Eligibles (ICD): Medicaid is scheduled to implement this demonstration in early 2015, testing a unique approach to bundled care management and support services, care coordination contracts and electronic messaging tools that will inform our multi-payer reforms beyond the test period. One component of the ICD will

support Medicaid beneficiaries through federated analytics and intensive care management associated with Medicaid's medical ASO. The other component of ICD will introduce local multi-disciplinary networks known as "health neighborhoods", which may align with the HEC. Our model test will not introduce duplicative services or payment.

Behavioral Health Homes (BHH): The BHH model aims to improve care and reduce costs for Medicaid recipients with serious and persistent mental illness. BHH assess, identify and coordinate the physical and mental healthcare needs. Local mental health authorities will receive a fee for care management and coordination, assistance with transitions, and referrals to community supports. Payment for BHH services will not duplicate payments made under Medicaid for covered services, including those associated with the model test. The BHH will provide valuable experience in serving a special population that is not a primary focus of our model test, but will inform SIM related multi-payer innovations in the future

WrapAround New Haven: CMMI recently awarded a $9.7 million, 3-year grant to Clifford Beers Clinic for an intensive care coordination intervention targeting children at risk for trauma and their families. Working with a health center, public schools and DSS, the program seeks to improve health outcomes through integration of behavioral health and medical care as well as payment reforms that supports care coordination for high-risk beneficiaries.

X. Sustainability After the Period of Performance

Plan to sustain the innovation initiatives.

Program Management Office: The annual insurance assessment upon which the Program Management Office (PMO) was established is ongoing and will continue to provide support for multi-payer alignment and the coordination of related initiatives. The SIM Governance Structure and the associated quality measure alignment, Value-based Insurance Design, and stakeholder engagement initiatives will be sustained after the performance period by means of the annual insurance assessment.

Connecticut's insurance assessment methodology is based on an assessment/apportionment on the CT Domestic Insurance Industry that writes Direct Written Premiums in CT only (CT Business only). Annually, the Connecticut Insurance Department (CID) requests premium tax liability information from the Department of Revenue Services from the previous calendar year. (Premium tax liability info is a company's Direct Written Premium times the premium tax of 1.75% which equals their premium tax liability that the CID receives). Each company's portion is related to their individual proportion to the industry total (the sum of all the assessed company's individual premium tax liability amounts. There are approximately 100 CT Domestic companies that are assessed.)

The total dollar amounts that are subject to Assessments are the total appropriated budgets of the CT Insurance Department and the Office of The HealthCare Advocate – Salaries, Fringes, Other Expenses, Equipment and Overhead, and Parts of these other State Agencies – OPM, Aging and DMHAS. Monies collected from the Assessments are deposited into a separate, non-lapsing fund called the Insurance Fund. 100% of the expenditures of the CID and OHA—and

beginning this year, the SIM Program Management Office— are paid out of the Insurance Fund – with no monies / resources / funding received from the General Fund / State of CT.

The assessment is calculated during the first quarter of the fiscal year (Summer) based upon CID's and OHA's appropriations from the previous Legislative Session which ends in May/June. Any monies left in the Insurance Fund at the end of the Fiscal Year – 6/30/xx (lapses….) is credited back to the Insurance Industry on their next assessment when it is calculated (Summer).

Timing:

- June / July – Assessment is calculated
- August 1 - Notice of Proposed Assessment is sent to CT Domestic Insurance Companies with a 30 day look / objection period, if none are received –
- September 1 is first quarterly billing of the fiscal year, followed by quarterly billings on – December 1, March 1, and June 1.

Relevant statutes can be found at C.G.S. 38a – 47 thru 52. Public Act (PA) 14-217 amended these statutes in order to establish funding for the PMO.

The annual insurance assessment includes a modest budget for practice transformation support, which we anticipate will be ongoing. The state is proposing to substantially supplement these practice transformation funds with the proposed SIM Model Test grant investments. In summer of 2018, the state will assess whether the state is achieving its projected goals, whether and to what extent practice transformations appear to be contributing to improvements in the state's performance, and the projected need for such support after the performance period. Based on the estimated need, the state will pursue an appropriation for additional state funding for the SFY20 and SFY21 biennium. The PMO will be responsible for bridge funding from the close of the performance period to the start of the SFY20/21 biennium. We do not currently plan to

continue Innovation Awards beyond the performance period. Finally, the PMO budget includes funds to cover the ongoing costs for evaluation, which we intend to continue at reduced scope beyond the performance period.

Department of Public Health (DPH): The majority of the costs of implementing the Population Health plan are not included in our SIM Model Test grant request. Consequently, we intend to seek an appropriation for the SFY18/19 biennium and funding that might be available through other grant opportunities to cover the costs of implementing Health Enhancement Communities and other recommendations contained within our population health plan. The state will seek appropriations for an expansion of the Health Enhancement Community demonstration in future years if the anticipated benefits in health and costs are borne out in our evaluation. Sustainability can also be affected by strategic partnerships that may include philanthropies, private payers, or other entities that have interest and synergies. Once models are set up and evaluated, activities that enhance or improve capacity of the health system will be integrated at the state and community level, representing new and improved ways of doing business.

Department of Social Services (DSS) – Medicaid QISSP: The value of the Medicaid Quality Improvement and Shared Savings Program (QISSP) and multi-payer alignment will be assessed ongoing. Assuming favorable results, we anticipate that such programs would continue to align with the Medicare Share Savings Program (SSP) and subsequent iterations of this program. SIM grant funds will support the start-up and initial administrative costs associated with the Medicaid QISSP program. The costs of ongoing administration of the Medicaid QISSP will be accommodated within the overall Medicaid appropriation, to the extent that the program continues to have the desired impacts on the quality and efficiency of care.

DSS HIT: We estimate the Health Information Technology (HIT) infrastructure and operating costs between $3.6-4 million annually, including costs associated with support provided by the University of Connecticut Health Center (UCHC). After the SIM grant, these costs will be borne by the state (25%), Medicaid (25%), and Others (hospitals, FQHCs, ACOs, IPAs) to enhance and invest in the state HIT infrastructure for delivery of quality care.

Workforce: The following sustainability plan applies to workforce initiatives:

- Community Health Workers (CHW): SIM Test Grant funds will help develop and launch a CHW training and certification program. Department of Labor funds are already supporting the development and launch of the community college participation in the program. Once our overall program is firmly established, tuition will be charged for the courses, although we will seek grant funds from both private and public sources to subsidize tuition.
- Inter-professional Education (IPE): SIM Test Grant funds will help meet the development costs of coordinating all of the inclusion of all of Connecticut's health professions schools, and expanding our current urban IPE program (Urban Service Track) to cover disadvantaged populations throughout the state. Once our statewide program (i.e., Connecticut Service Track, see response to question 20) is established, participating health professions undergraduate and graduate programs will support the inclusion of their students and residents by paying for each student and resident to cover CST's costs per participant that are over and above in-kind contributions made by instructors, mentors and the institutions or providers that are venues for CST.
- Teaching Health Centers: SIM Test Grant funds will support the development and preparation of the Connecticut Teaching Center Coalition so that it can effectively seek support from HRSA's teaching health center program and also from private sources, such as the Macy

and Pew foundations. Once our primary care residency programs are established, we expect them to be allocated GME slots and to be supported by GME funding.

Sustainability of staffing levels.

Program Management Office: The legislature has established and allocated funding for nine positions in the PMO. SIM Test Grant funding will support an additional seven positions, with the following plan for sustainability:

- Research analyst – The test grant period will enable the state to establish a new relationship with UConn to design, test and implement rapid cycle evaluation methods and processes with our state agency and private payer partners. We believe that this position will not be needed after the test grant period with methods established and reduced scope evaluation activities.
- Practice transformation manager and 3 health program associates (HPAs) – The ongoing need for all of these positions will depend on the evaluation of practice transformation activities funded under the SIM test grant, and the extent to which there continues to be a need in the provider community for substantial assistance with practice transformation. If the scope of ongoing practice transformation activities warrants the continuation of one or more of these positions, funding will be sought through the appropriations process.
- Grants/contracts specialist – With the anticipated reduction in the scope of the PMO's work after the SIM grant, especially with respect to the number of contracts, we believe this position will no longer be necessary.
- Nurse consultant – The need for this position will be reassessed during the second implementation year and, if required, will be funded ongoing as part of the established PMO budget.

DPH – Population Health: As stated above in the response to 1a, the majority of the costs of implementing the Population Health Plan are not included in our SIM Model Test grant request. We intend to seek an appropriation for the SFY 18/19 biennium and other grant funding to cover the costs of implementing recommendations and associated staff critical to that activity. With respect to the Population Health Plan, critical staff for implementation includes the 9 positions requested for funding under the SIM Test Grant Application, as well as continuation of contractor ICF Macro that administers the BRFSS survey and enhanced sampling to support multi-year trend analysis for small area estimates on population subgroups.

DSS – Medicaid QISSP: SIM funded staffing support from the Department of Social Services includes a state-supported Health Program Assistant position. This position will be procured through the typical civil service justification and recruitment process. This Health Program Assistant position will be assigned within the Department's Division of Health Services Integrated Care Unit. All other activity (e.g. relating to QISSP) will be performed in the early stages of the grant period by the Department's contractor, Mercer. Ongoing oversight of this shared savings initiative will reside within the Department's Divisions of Health Services and Finance, as well as be supported by the Department's medical Administrative Services Organization (ASO), Community Health Network (CHN). The required level of staffing will be re-assessed in SFY17 and an adjustment to the Department's appropriation will be sought as necessary.

The Department's Division of Financial Services will also require two positions to support QISSP. One of these positions, an Associate Accountant, will be assigned to work closely with the actuarial support consultant, Mercer, throughout the following range of activities: State and federal budget development and analyses; financial modeling of proposed shared savings

arrangements; detailed development, review and maintenance of shared savings calculations; data review and analyses in support of financial modeling and budget activities; and financial support for contract development and monitoring activities. In addition, the Division of Financial Services will also require an Accountant position to meet the reporting requirements associated with the project. This position will also provide needed support to the above position to meet expected peak workload demands and other priority financial assignments related to the SIM.

DSS – HIT: UCHC staffing costs are among the overall HIT costs that we anticipate will be borne by the state (25%), Medicaid (25%), and Others (hospitals, FQHCs, ACOs, IPAs) after the conclusion of SIM funding.

Plan to integrate the contractors' work following the SIM period of performance.

Program Management Office: As noted earlier, the annual insurance assessment upon which the PMO was established is ongoing and will continue to provide support for the continuation of the SIM Governance Structure. Together, the SIM PMO and Governance structure provide the resources to support ongoing coordination of state agencies, payers, and various stakeholders, and the integration of the work of those contractors that continue beyond the period of performance.

The PMO is proposing to contract for practice transformation support (advanced medical home and community and clinical integration program) and evaluation services. After the performance period, the state intends to continue these contracts because the skills and expertise required of such contracts cannot be easily established and maintained within a state agency structure. Our intent is to use practice transformation vendors who have the capability to apply the state of the art in transformation support and process re-engineering. These are among the contracted supports (like our ASO model for Medicaid management) that do not lend themselves

to incorporation into the state agency infrastructure. A similar strategy will be employed for evaluation services. We intend to continue to rely on the services of UConn or other academic or research partners with expertise in rapid cycle and program evaluation.

DPH: Contractors for Population Health (Macro International (BRFSS interviews), Demographic modeling (town level population estimates), and Population Health Plan Facilitation) require specialized skills, knowledge of content areas, and dedicated time to support development of the Population Health Plan. With the exception of Macro who is utilized on an ongoing basis, the consultants are short term and will not continue after the SIM Test period. The expected results are a Population Health Plan that will be implemented through multi-sector partnerships at the state and community level with coordination by dedicated SIM staff at DPH.

DPH will contract with the existing vendor (Macro) for BRFSS interviews and will seek a qualified demographer who can develop a methodology to generate valid population estimates by race and ethnicity for each of the 169 towns in Connecticut. The models developed for town level population estimates established by the demographics consultant will be implemented by the Epidemiologist3 position in future years. Along with the specific skills needed, current staffing levels at DPH do not allow for dedicated time to produce models and estimates. DPH will also seek capable vendors that have prior experience developing the state's Healthy Connecticut 2020 State Health Improvement Plan. In this way the contractor will have knowledge of Connecticut's structure and environment, experience working with sectors and partners involved in initial planning, and demonstrated skills in community engagement, facilitation of diverse groups discussing complex issues, and statewide health improvement planning

DSS – Medicaid QISSP: Actuarial and other staging work performed by contractor Mercer in support of the Medicaid QISSP will occur in the early stages of the grant period. Ongoing, oversight of the means and method of assessing eligibility for, as well as distributing, shared savings will reside in the Department of Social Services' Divisions of Health Services and Finance, and will be supported by the Department's medical ASO (CHN), and MMIS contractor (HP).

DSS - HIT: Most of the SIM HIT infrastructure costs are associated with the purchase and maintenance of technology. The state will continue to procure services from vendors that are relevant to the operations to support interoperability. We estimate HIT infrastructure and operating costs between $3.6-4 million annually. Finally, the state occasionally relies on agreements with UConn and UCHC to perform ongoing administrative functions that might otherwise reside within a state agency. UCHC personnel currently provide support to DSS related to the administration of the EHR incentive program, business intelligence competency center, and health information exchange. Accordingly, we anticipate that the support for SIM HIT initiatives that will be provided by UCHC personnel will be ongoing.

XI. Scaling to Statewide Implementation

All of the individual elements of our proposal are statewide as of the start of the period of performance (1/1/16), since none of the elements are geographically bounded and may involve providers and beneficiaries throughout the state. The exception is the model recommended as a result of our Population Health planning, which will not be substantially implemented until after the SIM period of performance (January 1, 2019). Although there are no geographic boundaries for the elements of our model test, we will be undertaking a process to maximize statewide participation of providers and beneficiaries over the period of performance.

Plan for Improving Population Health	Planning for scale and statewide implementation for population health interventions will be incorporated into the population health planning process in years 1, 2 and 3. The Prevention Services Center demonstration phase will be evaluated in year 4 and key aspects of evaluation will focus on scalability elements (e.g. financing, staffing, and physical plant requirements, nature of relationship with AMHs). Health Enhancement Communities are envisioned as targeting areas in the state with highest disparity and are not proposed for scale or state-wide implementation during the SIM period of performance, nevertheless planning for scale will occur throughout the performance period (e.g. facilitated population health planning team meetings and/or workgroups specifically focused on scalability planning.
SSP payment reforms based on care experience and quality	This initiative begins statewide. Beneficiary participation is projected to scale to 64% by the end of the period of performance (2018) and to 85% by 2020 (see response to Question 7).
Medicaid QISSP/AMH/CCIP	The Medicaid QISSP, AMH and CCIP programs will be made available to providers statewide by competitive procurement with the first wave of participants to begin 2016. Beneficiary and provider participation in Medicaid QISSP will increase in two subsequent waves in 2018 and 2020, by which time participation should include the great majority of providers and

	Medicaid beneficiaries (90%) as illustrated in our response to Question 7.
Value-based Insurance Design	This initiative begins statewide. Beneficiary participation is projected to scale to nearly 85% by 2020 (see response to Question 7).
Quality Measure Alignment	This initiative begins statewide. Our goal is to implement quality measure alignment for all Advanced Networks in 2016, as well as those FQHCs participating in the Medicaid QISSP.
Workforce Development	Our workforce initiatives will support workforce development statewide.

XII. Recruitment Process

PMO: Assuming notice of award by October 31, 2014, we anticipate that PMO positions will be formally established by January 2015 and hired between March and April, 2015. The PMO/Director of Healthcare Innovation will offer three sessions of a "New Staff Orientation to SIM and State Agencies" to educate new hires about the SIM initiative and activities related to health system transformation. We intend to offer these sessions to PMO, DSS, DPH and UCHC hires in March, May and July, 2015. In addition, we will integrate DSS- and DPH-led orientation sessions so that all SIM involved staff have an understanding of the scope, history and inter-dependence of these agencies and their programs and activities.

DSS- MQISSP: The Department of Social Services will utilize its existing civil service recruitment and hiring process. From the point of articulating need for a position through the process of gaining approvals from the Department of Administrative Services and the Office of Policy & Management to interview and hiring process typically takes six months of lead time.

Assuming notice of award by October 31, 2014, we anticipate that DSS positions will be formally established by January 2015 and hired between March and April, 2015. Agency and program specific orientations, and mentoring of job duties will be provided by hiring supervisors.

DPH: follows state operations and processes for hiring set by the Office of Policy and Management and the Department of Administrative Services. The processes for recruitment, interviews, and selection are consistent with negotiated union contracts, and Affirmative Action and Equal Opportunity laws. Timeframes for receiving approvals to hire, posting position vacancies, candidate interview and selection process, and administration for formal hiring takes approximately 3 months under normal circumstances and up to 6 months or more particularly if recruitment requires an examination process to update and populate a list of eligible candidates that can apply for the open positions.

Each agency will be asked to prioritize hiring of positions according to critical need and based on the operational plan and timeline. It is anticipated that hiring will occur in three waves. For the Population Health component of the SIM Test application, DPH will be responsible to hire 8 positions and administer a funding change for the Organizational Development Specialist, a critical existing position that supports foundational work related to population health, and the quality and performance of the public health department. The CDC funding for the Organizational Development Specialist ends in December, 2014. Continued funding is available for this position through PHHS block grant until October 1, 2015. This opportunity became available this spring as part of the one-time supplemental PHHS block grant funds provided to the state. Given this, we propose to use SIM funds beginning 10/1/2015 and have adjusted the budget accordingly.

The other positions will be prioritized as follows:

- Priority 1: Physician 2, Health Program Associate, Secretary 2, Epidemiologist 3 (SIM/DPH): This will establish and staff a DPH SIM office that will do the majority of work for the Population Health Plan.
- Priority 2: Epi 2 (BRFSS), Health Program Associate (Local Health), Prevention Service Coordinator (SIM/DPH). These positions are supportive to contractor work or positions identified above.
- Priority 3: Epi 3 (BRFSS). Position and funding is needed beginning in Year 2.

Agency and program specific orientations, and mentoring of job duties will be provided by hiring supervisors. Attendance at specific national meetings and conferences will supplement the orientation and mentoring by keeping new staff current with technical skills, and engaged with acquiring knowledge on trends and innovations in health system transformation.

Public health agency program specific orientations will be provided by supervisors. Attendance at specified national meetings and conferences are included for the Physician 2, and Epidemiologist 3 and 2 to assist these positions with ongoing knowledge in key programmatic areas as BRFSS, data analysis, health equity, and the evidence base.

DSS – HIT: UCHC will hire staff to support HIT initiatives during the first 4 months of the grant. At this time we do not anticipate any special training for these staff besides general orientation to the SIM initiative and general overview of the inter-relationship between SIM funded initiatives and Connecticut's HIT strategic and operational plan.

XIII. Integrating Care Delivery, Payment and Population Health Planning

The proposed collaboration under SIM among state agencies builds on a solid foundation of joint initiatives in related areas. Several departments of the state are meaningfully involved in

collaboration in support of addressing social determinants of health (SDH), illustrative examples include:

- The Department of Public Health (DPH) is collaborating with the Department of Social Services (DSS) and other stakeholders on the national Collaborative Improvement & Innovation Network (CoIIN) to Reduce Infant Mortality, whose goal is to reduce infant mortality and improve birth outcomes. DSS already has diverse strategies in place, including medical ASO Intensive Care Management support for women with high risk pregnancies, PCMH support, an obstetrics pay-for-performance project designed to increase the incidence of full-term vaginal births, and the dental ASO effort funded by HRSA under which pregnant women are being engaged for purposes of preventative oral health - including such strategies as primary care providers issuing "prescriptions" for dental visits. In collaboration with DPH, these strategies and others will be coordinated across payers with the intent of improving outcomes.
- Additionally, the Department of Children and Families (DCF) is partnering with DSS, DPH, legislators, judges and other stakeholders on the Three Branch project. Three Branch is a multi-state initiative convened by the National Governors Association Center for Best Practices, the National Conference of State Legislatures, Casey Family Programs, the National Center for State Courts, and the National Council of Juvenile and Family Court Judges. The aim of the Three Branch Institute is for participating states to improve social and emotional well-being for children in foster care.
- Finally, DSS, DCF and the Department of Mental Health & Addiction Services are collaborating with the Clifford Beers Child Guidance Clinic in support of its CMMI Innovations Grant, WrapAround New Haven- Family Centered Model of Care. The

wraparound process is an intensive, individualized care management process for youths with serious or complex needs. Teams of individuals who are relevant to the well-being of the child or youth (e.g., family members, other natural supports, service providers, and agency representatives) collaboratively develop an individualized plan of care, implement this plan, and evaluate success over time. The wraparound plan typically includes formal services and interventions, together with community services and interpersonal support and assistance provided by friends, kin, and other people drawn from the family's social networks.

In the context of SIM, we aspire to build on these ongoing collaborative initiatives and aim to ensure that the Plan for Improving Population Health and the proposed Payment and Service Delivery Model will be mutually informative and re-enforcing particularly with respect to addressing social determinants of health and health equity. The following specific activities and mechanisms to achieve integration are planned:

- As described on page 2 of our application, the Population Health Council is responsible for developing the Population Health Plan. It will be developed from the members of the Advisory Council and Health Systems Work Group of the DPH-led State Health Improvement Planning Coalition. This Coalition is comprised of representatives from key sectors and health stakeholders including hospitals and community health centers, Departments of Education Transportation, and Environmental Protection, various community coalitions, and philanthropies. We will use the Sector and Stakeholder Wheel to ensure broad representation and identify key agencies and offices with potential influence over SDH to be included on the Population Health Council. Illustrative examples include the Office of Early Childhood, Department of Housing, Insurance, Social Services and other payers.

Within the Population Health Council, a five to six member executive committee will be formed to inform and guide the work of the Council. Participants of the executive committee will collaborate closely and share decision making authority. Led by DPH, the committee will include, for example, representatives from DSS , the PMO, and key entities and organizations with specialized knowledge and expertise in SDH.

- The Population Health Council will review potential health equity and SDH priorities and measures and make a recommendation to the Quality Council for inclusion of such measures in the common quality scorecard by year 3. The DPH chronic disease director, Mehul Dalal, MD, is one of the chairs of the Quality Council. By serving in this role, DPH will have a thorough grounding in the parameters for scorecard development and the relationships with payers necessary to support the gradual introduction of SDH considerations in measure selection in general, and as it pertains to our goal to reduce health equity gaps.
- The Population Health Council, as part of its review of evidence-based interventions and root cause analyses work to identify priority areas for action to advance health equity (page 2) will make specific strategy recommendations to the Practice Transformation Task Force and Health Equity and Access Council to inform their work in advising service delivery and payment reform implementation. The Population Health Council will also be invited to review and comment on the CCIP plan prior to implementation (by July 2015), especially as it relates to technical assistance in priority areas on which SDH has direct bearing including community integration and reducing health equity gaps.
- To ensure that Population Health planning is current with on-the ground experience with practice transformation and payment reform, the Medicaid QISSP, CCIP, and VBID leads will be requested to submit and/or present formal progress updates to the Population Health

Council quarterly. CCIP and in particular, will be well positioned to assess, from the primary care practice perspective, gaps and needs in community-based preventive services that could inform the design of PSCs and ultimately HECs.

- The DPH-based Population Health Planning leads will participate in SIM Core Team meetings to ensure that the practice transformation and payment reform initiatives are current with developments and recommendations of the Population Health Council. In addition DSS will consult on a regular basis with DPH Population Health Planning leads regarding Medicaid QISSP design, implementation and monitoring.
- Medicaid QISSP participating FQHCs and Advanced Networks will be required to integrate use of community health workers and other specific strategies designed to address social determinants of health (e.g. assessment processes that gauge food security, physical safety and housing stability as a threshold to beneficiary readiness to engage on matters related to physical and behavioral health).
- Finally, DPH, DSS, and the PMO will execute a Memorandum of Understanding that details their joint planning and administrative responsibilities by January 2015.

Sector and Stakeholder Wheel for Population Health Planning